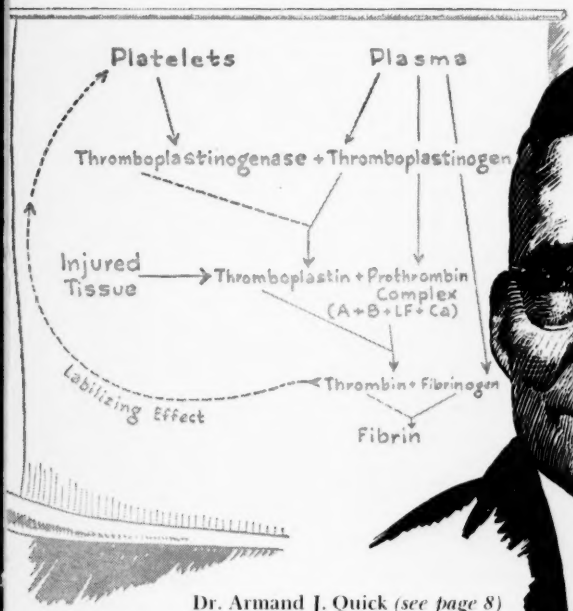
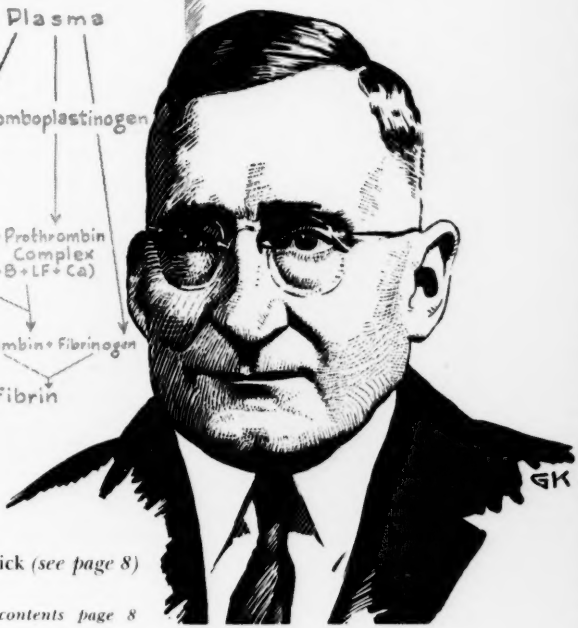
JULY 15, 1949

MODERN MEDICINE

The Journal of Diagnosis and Treatment





Dr. Armand J. Quick *(see page 8)*

A good night's rest
A good day's work

Allergic patients get both, with just 4 small doses

Comfort 'round-the-clock for your allergy patients . . . Decapryn provides long-lasting relief with low milligram dosage. "Symptoms were relieved from 4 to 24 hours after the administration of a single dose of Decapryn—"[1]

"It was found that 12.5 mg. could be given during the day with comparatively few side reactions and yet maintain good clinical results—"[2]

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Decapryn® SUCCINATE

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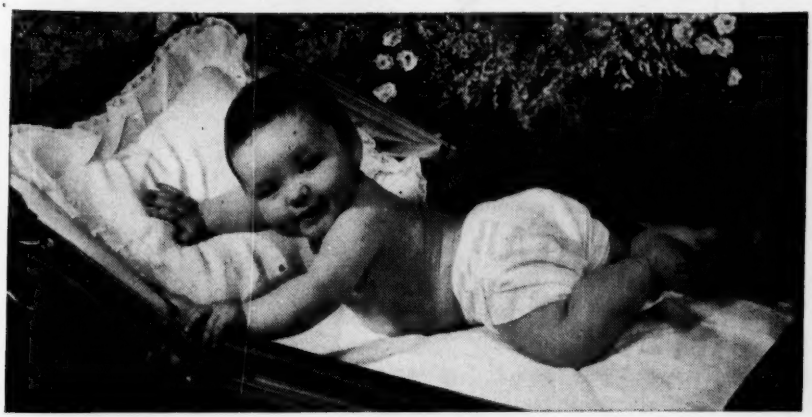
THE LONG-LASTING LOW-DOSAGE ANTIHISTAMINE

12.5 mg. tablets, P. R. N. Also available in pleasant tasting syrup especially designed for children. 6.25 mg. per 5 cc) and 25 mg. tablets.

1. Sheldon, J. M. et al: Univ. Mich. Hosp. Bull. 14:13-15 (1948). 2. MacQuiddy, E. L.: Neb. State M. J. 34:123 (1949)

How Baby Lotion 10FA* reduces summer incidence of MILIARIA



Over a period of two years, the effects of skin care preparations were studied in a large Chicago hospital. 2,077 infants were observed.

With ordinary methods, case incidence of miliaria rose as high as 55% during the summer months. But among infants given routine skin care with Lotion 10FA,* an oil-in-water emulsion, the incidence dropped as low as 3%—*and there was not one case of impetigo.*

A complete report of these extensive studies appeared in the *American Journal of Diseases of Children* (March, 1948). A significant excerpt:

"One important advantage of Lotion 10FA* accrues from the inherent discontinuous, but protective, film, which does not interfere to any significant degree with the metabolic and respiratory functions of the skin."

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Please send me 12 free distribution samples of Johnson's Baby Lotion.

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Offer limited to medical profession in U.S.A.

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● Pfizer Dihydrostreptomycin Sulfate is a new antibiotic prepared by the hydrogenation of streptomycin.

Dihydrostreptomycin exhibits essentially the same range of antibacterial activity as streptomycin but may be administered for longer periods of time with a lower incidence of vestibular damage. Recent clinical evidence[1,2] has shown that Dihydrostreptomycin produces symptoms of neurotoxicity slowly: for example, less tinnitus, less paresthesia, and fewer visual difficulties during the early periods of treatment.

Dihydrostreptomycin has become the drug of choice in the treatment of many forms of tuberculosis.

Pfizer Dihydrostreptomycin Sulfate is available to the medical profession through a number of leading pharmaceutical companies. Each lot is exhaustively assayed chemically and biologically. Chas. Pfizer & Co., Inc., 630 Flushing Ave., Brooklyn 6, N. Y.

1. *Hinshaw, H. C., Feldman, W. H., Carr, D. T., and Brown, H. A., Am. Rev. Tuberc. 58:525 (Nov.) 1948*
2. *Hobson, L. B., Tompsett, R., Muschenheim, C., and McDermott, W., Am. Rev. Tuberc., 58:501 (Nov.) 1948*

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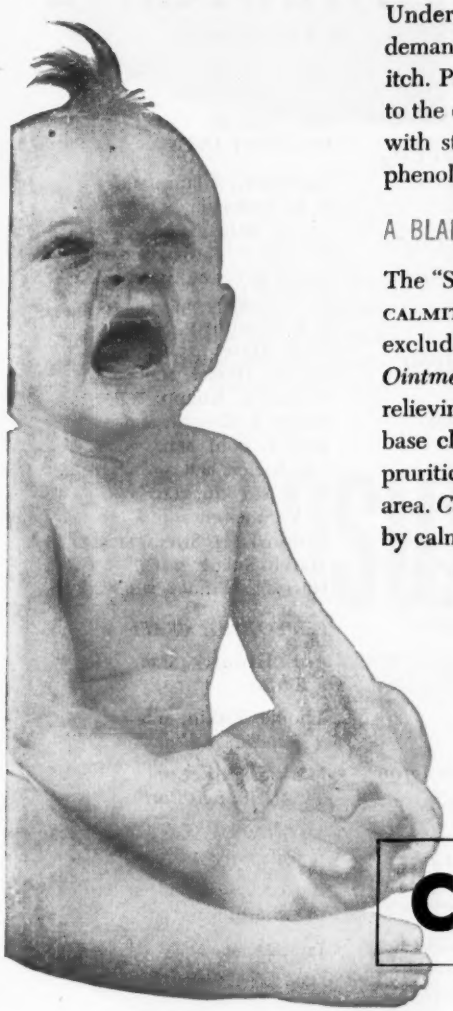
Manufacturing Chemists Since 1849

a loud and insistent appeal



Understandably urgent, the pruritic infant demands rapid, *SAFE* control of symptomatic itch. Pediatricians, in particular, must be alert to the dangers of "imprudent topical therapy"[1] with stimulating or keratolytic drugs such as phenol, cocaine and cocaine derivatives.[2-6]

A BLAND AND EFFECTIVE RESPONSE

The "Safety First" of antipruritic treatment is CALMITOL OINTMENT, expressly formulated to exclude dangerous medicaments. *Calmitol Ointment* is promptly and lastingly effective in relieving the torments of itch. Its fine emollient base clings intimately and protectively to the pruritic lesion and the surrounding affected area. *Calmitol Ointment* calms the little patient by calming the pruritus.

1. Gaul, L. E.: J.A.M.A. *127*:439, 1945.
2. Underwood, G. B., and Gaul, L. E.: J.A.M.A. *138*:570, 1948.
3. Underwood, G. B.; Gaul, L. E.; Collins, E., and Mosby, M.: J.A.M.A. *130*:249, 1946.
4. Andrews, G. C.: Disease of the Skin, Philadelphia, W. B. Saunders Co., 1946.
5. Ormsby, O. S.: Diseases of the Skin, Philadelphia, Lea and Febiger, 1937.
6. Gaul, L. E.: Hygeia 23:280, 1945.

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MODERN MEDICINE

THE JOURNAL OF DIAGNOSIS AND TREATMENT

description

Smooth, refreshing, chocolate-mint-flavored suspension of nontoxic SULFASUXIDINE® succinylsulfathiazole (95% retained in bowel), 10%; *Pectin*, 1%; and *Kaolin*, 10%. Particularly well accepted by infants and children. Toxicity is negligible.

indications

Nonspecific diarrhea, especially the "summer complaint" of infants. Consolidates fluid stools, soothes inflammation, checks enteric bacteria, detoxifies products of enteric putrefaction.

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Sulfasuxidine® suspension with pectin and kaolin

dosage

Infants: 2-3 teaspoonfuls, 4 times daily.
Children: 1-2 tablespoonfuls, 4 times daily.
Adults: 2-3 tablespoonfuls, 4 times daily.
Supplied in 16 fl. oz. *Spasaver*® bottles.
Sharp & Dohme, Philadelphia 1, Pa.

SHARP & DOHME

Contents for July 15 1949

VOL. 17, NO. 14

THE MAN ON THE COVER is Dr. Armand J. Quick, professor of biochemistry at Marquette University, Milwaukee. He is shown with the chart he prepared to illustrate an article on hemophilia which appears on page 46 of this issue. An active author and research scientist, Dr. Quick is particularly interested in hematology. In 1944 his scientific exhibit at the American Medical Association Convention was awarded a gold medal. He has been teaching at the Marquette University School of Medicine since 1935.

Basic need is met when 'Surfacaine' (Cyclomethycaine, Lilly) is applied to damaged, irritated, or diseased skin and to rectal or genito-urinary membranes. Sustaining comfort is provided promptly and thoroughly, yet safely, with this new type of surface anesthetic.

Relief from pain usually lasts up to eight hours with 'Surfacaine.' However, it may be reapplied freely at shorter intervals, if necessary, and over extensive areas. Unlike topical analgesics whose value is sharply limited by high toxicity, 'Surfacaine' may be used liberally.

It is soothing to the tender skin of infants with diaper rash, to burns that are superficial or deep, to painful hemorrhoids, and to itching skin conditions.

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Ointment 'Surfacaine,' 1 percent, in 1-ounce tubes with removable, perforated rectal tips and in 1-pound and 5-pound jars

Cream 'Surfacaine,' 0.5 percent, in 1-ounce tubes and in 1-pound and 5-pound jars

Lotion 'Surfacaine,' 0.5 percent, in 4-ounce and 1-pint bottles

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Suppositories 'Surfacaine,' 10 mg., and Sulfadiazine, 325 mg., in packages of 12

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Contents for July 15 1949

CONTINUED

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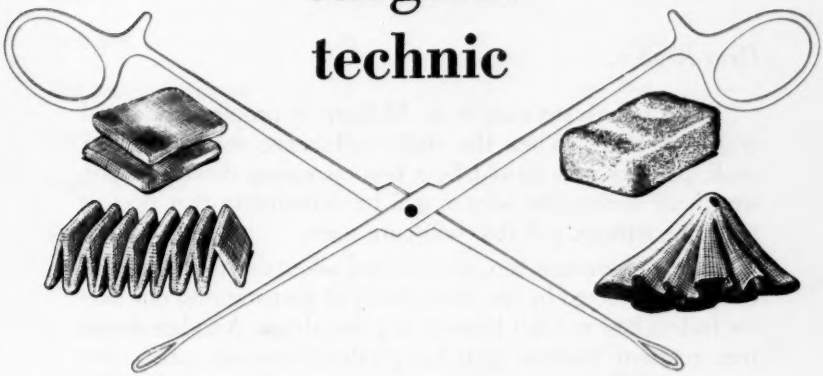
a *refinement* in surgical technic



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In general surgery and in the specialized branches of surgery OXYCEL (oxidized cellulose, Parke, Davis & Company) aids the operator by stopping bleeding not readily controllable by clamp or ligature. This refinement in surgical technic is made possible by the distinctive features of OXYCEL:

hemostatic Promptly and effectively controls bleeding;

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OXYCEL is supplied in individual screw-capped bottles.

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Sterile 3" x 3" eight-ply pads

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LETTER FROM THE EDITOR

Dear Reader:

Next month the rush is on. Millions of people are afflicted with hay fever. When the sniffle-and-sneeze season hits the peak, patients who should have been receiving desensitization treatment during the winter will be demanding that doctors prescribe a magic pill that will cure them.

Some physicians, too, are confused about the antihistaminic drugs. Bewildered by the multiplicity of preparations, one doctor feels it best to limit himself to a few drugs. Another doctor tries rotation. Neither plan has produced entirely satisfactory results, and the rotation plan may convince a dissatisfied patient that the doctor doesn't know what he is doing.

Clarification of the hay fever problem is certainly indicated. Early this year the editors of MODERN MEDICINE prevailed upon Dr. Albert V. Stoesser of the University of Minnesota to accept that assignment. Dr. Stoesser, a regent of the American College of Allergists, has been an active practitioner and teacher of medicine since 1929. We asked him to present an up-to-date review of hay fever therapy. He did just that.

Dr. Stoesser's contribution is authoritative but not dogmatic. Helpful and stimulating, it provides the information and background for successful therapy.

Among other things, the paper contains a classification of antihistaminic drugs by clinical behavior, *to our knowledge the first clinical classification to be published.*

The paper is being set in type now and will appear as the Special Article in the August 1 issue of MODERN MEDICINE. It contains much besides the discussion of antihistamines. Skin tests and specific pollen therapy are not minimized. Neither is the value of instruction of the patient. If you want to be up to date on hay fever make a note now to open the next issue of MODERN MEDICINE to the Special Article, "What Can Be Done for the Hay Fever Patient?"

Allergy	Total Cases	No. Benefited	% Benefited	% Side Reactions
Hay Fever	562	387	68.8	11
Vasomotor Rhinitis	133	87	65.4	8
Asthma	189	82	43.3	6
Urticaria	48	39	81.2	11.5
Angioneurotic Edema	12	8	66.6	0
Contact Dermatitis	18	12	66.6	7.6
Atopic Eczema	17	14	82.3	40
Serum Sickness	3	3	100.0	0
Migraine	10	7	70.0	25
Allergic Headache	5	3	60.0	0
Drug Allergy	2	2	100.0	0
	999	644	64.5	10.9

Here's the Evidence

---based on clinical findings in 999 cases

NEOHETRAMINE® IS EFFECTIVE. It is useful in many patients in whom other antihistaminics produce marked sedation or other undesirable side-effects in the management of hay fever and other allergic disorders.

NEOHETRAMINE IS LESS TOXIC than other available antihistaminics; its lower toxicity is quantitatively more pronounced than its lower effectiveness.

Prescribe **NEOHETRAMINE HYDROCHLORIDE,** brand of Thonzylamine Hydrochloride.

Tablets: 25 mg., 50 mg., 100 mg., Syrup—6.25 mg. per cc.—bottles of 1 pint and 1 gallon.

Neohetramine is the registered trademark of the Nepera Chemical Co., Inc., for its brand of Thonzylamine—N,N-dimethyl-N'-p-methoxybenzyl-N'-(2-Pyrimidyl) ethylene-diamine monohydrocnloride.

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Correspondence

Communications from the readers of MODERN MEDICINE *are always welcome. Address communications to The Editors of* MODERN MEDICINE, *84 South 10th St., Minneapolis 3, Minn.*

Cotton or Silk Thread Sutures

TO THE EDITORS: Referring to the correspondence on the use of cotton thread for sutures (Feb. 1, 1949, p. 18), we have for years used a wire frame for silk or cotton sutures. The frame is constructed by bending one piece of wire and brazing the ends (see illustration). The suture material is wound loosely on the frame for sterilization. One cut with the scissors at either end of the frame gives the proper length uniformly to each suture.

LAWRENCE SHINABERY, M.D.
Fort Wayne, Ind.

Should Not Omit Bronchoscopy

TO THE EDITORS: A brief comment on Diagnostix MM-140 deserves attention (Apr. 1, 1949, p. 84). The finding of carcinoma cells in the sputum does not eliminate the usefulness of bronchoscopy, which may provide much information if surgery is contemplated. The extent if any, of visible endobronchial involvement could thus be ascertained, forewarning the surgeon and contraindicating pneumonectomy with right main bronchus involvement, especially if reaching carina.

R. HARRISON FREEDMAN, M.D.
Stamford, Conn.

Only Two Specialties?

TO THE EDITORS: Will you ask your readers if I am dumb or just a plain "big head" and need a shoehorn to put my hat on?

I believe there are only two specialties in medicine: x-ray and pathology. What do the other so-called "specialists" know that I am not *supposed* to know? Please note the word *supposed,* which is important to maintain my credo.

I also think that for diagnosis I can do in my office with a good lab, a topflight x-ray man (hard to find), and a pathologist, everything to be done in any hospital and save a board bill and a bed.

Am I crazy or just ignorant? I often wonder. But I maintain these opinions until convinced of my error. The "G.P." in rural practice should know.

W. A. KILDUFF, M.D.
Dearborn, Mich.

Got Excellent Results

TO THE EDITORS: Some time ago I read a letter in the Correspondence section of *Modern Medicine* in which the author suggested sulfadiazine for erythema multiforme (Apr. 1, 1949, p. 18). I have since tried it in a case with excellent results.

L. J. CALAHAN, M.D.
Chico, Calif.

SO THIN...BUT SO STRONG...

Thin but strong is the metallic suture. Thin but strong are the gloves this surgeon wears. A special additive—*exclusive with SEAMLESS*—imparts exceptional strength to the rubber. Such strength makes possible the *extreme* thinness so essential at the finger tips. Carefully dipped on anatomically correct forms, these gloves fit well and flex easily. The surgeon's hands are "free" to work rapidly . . . And SEAMLESS Gloves "stay new" after repeated sterilization. That means *true* economy! . . . **THREE TYPES: Brown Milled (banded) — White Latex — Brown Latex**

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Infants of Diabetic Mothers

TO THE EDITORS: You will be interested in knowing that there has been a brisk demand for reprints of "The Care of the Newborn Baby of the Diabetic Mother," no doubt due to the article in *Modern Medicin* (Apr. 1, 1949, p. 68). Your review is in error when it says, "The infant is given oxygen, stimulated to cry, and placed in an oxygen incubator at 98° F." The statement should read, "Incubator temperature is kept at whatever temperature is necessary to keep the baby's temperature around 98°." Otherwise, the review is excellent.

J. E. GONCE, JR., M.D.

Madison, Wis.

Positive Hinton Test

TO THE EDITORS: In reference to the question of a still positive Hinton test in the patient with syphilis of the throat after injection of more than 10,000,000 units of penicillin *(Modern Medicine,* May 1, 1949, p. 28), I would recommend that in addition to the spinal fluid examination, the patient be followed with quantitative Kahn tests.

Frequently after penicillin treatment of syphilis the serology is not reversed for eight to ten months. A monthly followup with quantitative Kahn tests at the same laboratory will show a progressive reduction in titer indicating an adequate response to treatment.

FRANCIS W. EPSTEIN, M.D.

Toledo

100% Good

TO THE EDITORS: *Modern Medicine* is a 100% good medical publication.

F. A. ALLIN, M.D.

San Antonio, Tex.

"But my head aches now, doctor"

Until the basic cause is determined, relief can be given a patient suffering from headache pain through this simple expedient—ANACIN tablets. They work *fast* and for a prolonged period of time, exceeding the effectiveness of aspirin tablets. Anacin—the famous "A-P-C" formula—can be depended upon for uniformly excellent results.

ANACIN

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American Punch

TO THE EDITORS: Your excellent magazine is always most welcome. It is a kind of Father Confessor, Eye Opener, Medical Mirror, and American *Punch*, all in one. Everyone in the profession can surely benefit from the give (letters to the editor) and take (articles) contained therein.

E. M. BROEN, M.D.

San Pedro, Calif.

Likes Twice-a-Month

TO THE EDITORS: I have received much benefit from your biweekly publication as well as from *Modern Medicine Annual.*

M. E. SCOTT, M.D.

Hartselle, Ala.

Asthma in Elderly Patients

TO THE EDITORS: Dr. Mardoqueo F. Salomon states that chronic bronchitis in elderly asthmatic patients is "either a pure coincidental malady or else one of the manifestations of the left ventricular defect," and that the asthma in these patients is almost always cardiac. (*Modern Medicine*, Apr. 15, 1949, p. 18).

Of course, a number of patients in that age group are cardiacs whether or not they are affected by chronic bronchitis. However, the interpretation of what is usually termed chronic bronchitis in asthma as coincidental is erroneous. In fact, the actual background of chronic asthma associated with emphysema is in the majority of cases chronic nontuberculous bronchopulmonary disease, the origin of which can usually be traced to certain acute respiratory infections long before asthmatic symptoms appeared.

As I have stated in some of my publications (*Ann. Allergy* 5:364, 1947; *J.*

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new formula

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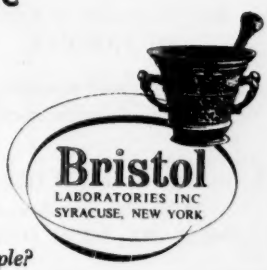
Ferric Ammonium Citrate, NF	667 mg.
Thiamine Hydrochloride (Vitamin B_1)	10 mg.
Riboflavin (Vitamin B_2)	4 mg.
Niacinamide	100 mg.
Liver extract (derived from 20 Gm. of fresh liver)	1 Gm.

Dosage: *Adults—one tablespoonful, t.i.d., with or immediately following meals; children—in proportion to age.*

Bottles of 12 fl. oz. and 1 gallon.

May we send you a tasting sample?



Pediat. 33:29, 1948), the history of these patients clearly indicates the development of bronchopulmonary disease following epidemic influenza and, more frequently, as a sequel to pertussis, bronchopneumonia, and similar respiratory episodes in childhood. Rather frequently, bronchographic studies in these patients reveal bronchiectasis in addition to pulmonary fibrosis and emphysema.

Although, as Dr. Salomon remarked, intravenous administration of aminophylline may be harmful if the patient also suffers from heart disease, this drug is most helpful in the majority of patients whose main difficulty is to expectorate tenacious bronchial secretion. In fact, it has saved the lives of many patients who otherwise would have suffocated during a severe attack.

On the other hand, demerol, although still advocated as useful in asthma, is definitely contraindicated in patients with excessive infectious bronchorrhea, because of its suppressing action on respiration and cough reflex.

The problem of chronic nonallergic asthma will be solved only by vigorous elimination by antibiotics of those respiratory infections from which chronic bronchopulmonary disease originates.

WALTER FINKE, M.D.
Rochester, N.Y.

Thiamine in Therapeutic Doses

TO THE EDITOR: The fact is well known to our profession that specific, curative therapy is used numerically far less than symptomatic treatment, and the reasons for this are also widely known. With this in mind I have, for the last three years, "enriched," to borrow the name used in process-

because children

and adolescents

grow so rapidly

their requirements are increased for the B Complex vitamins which Pentaplex supplies in a delightfully palatable and easily tolerated elixir.

Your young patients will *like* to take Pentaplex.

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Eskay's

Pentaplex

makes

B Complex therapy

palatable

ing white flour, all my symptomatic preparations by combining them with therapeutic doses of the vitamin which may be said to be universally deficient in the American diet, namely, thiamine.

Thiamine is so vital to the metabolism of every living cell that I reasoned that we physicians are passing up an opportunity of doing our patients a good turn during symptomatic treatment. With the use of thiamine combination, anorexia is overcome and increased metabolic demands for thiamine in fevers are met and satisfied. In many cases, especially respiratory, there seems to be some synergistic action between the thiamine and the symptomatic, or as we may call it, the active ingredient.

I have used, with excellent results, therapeutic doses of thiamine, usually 5 mg. per dose, combined with the active ingredient in tablets, elixirs, syrups, and capsules in the following drugs: respiratory (expectorants, sedatives), all vitamin and B complex (increased B_1 potencies), analgesic and antipyretic, chemotherapeutic (all sulfonamides), laxative, estrogenic and glandular (stilbestrol, thyroid, and so forth), sedative, hematinic, antacid and digestant, and sympathetic (amphetamine and so forth).

Of course it can be said, "Why not write a separate prescription for thiamine?" This can be done, but most physicians forget to do so and also the expense to the patient is higher. Moreover, the patient may not take both prescriptions faithfully, but the incorporation of thiamine in the single prescription insures the regular intake of the essential vitamin in therapeutic doses.

NATHAN BROWNSTEIN, M.D.
Allston, Mass.

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Of the many drugs used to lower arterial pressure in hypertension, Biologically Standardized veratrum viride (in CRAW UNITS*) is the only drug that produces a physiologic fall in blood pressure. VERATRITE represents a practical modification of this effective hypotensive drug for everyday management of the mild and moderate cases of essential hypertension. Prolonged action, wide range of therapeutic safety and complete simplicity of administration are specific advantages of Veratrite therapy. Each Veratrite Tabule contains: Biologically Standardized veratrum viride 3 CRAW UNITS; sodium nitrite 1 grain; phenobarbital ¼ grain.

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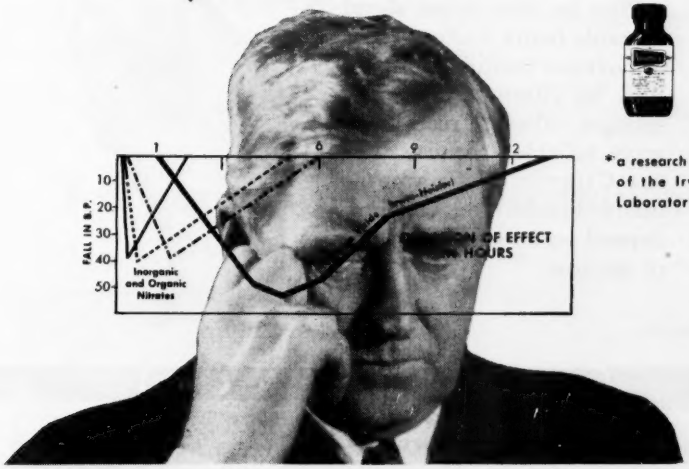

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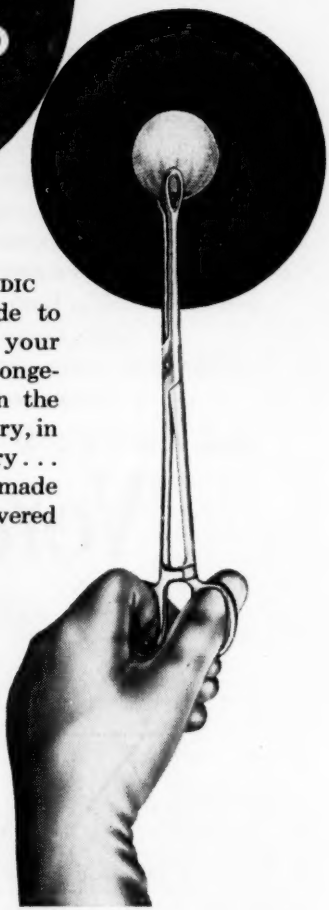

NOW, you can call for RONDIC *ball-shaped* sponges, ready-made to precision uniformity for all your needs. Designed for every sponge-stick use . . . in your office, in the examining room, in the laboratory, in the emergency room or in surgery . . . RONDIC sponges are precision-made of long-fibre cotton, securely covered with fine mesh gauze.

Why let your nurse spend valuable hours making those important round sponges? Rely on RONDIC *ball-shaped* sponges—always ready, always reliable, because they are CURITY, the name so many doctors and hospitals depend on for the widest line of sponges.

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Questions & Answers

All questions received will be answered by letter directed to the petitioner; questions chosen for publication will appear with the physician's name deleted. Address all inquiries to the Editorial Department, MODERN MEDICINE, *84 South Tenth Street, Minneapolis 3, Minnesota.*

QUESTION: A newspaper story described revivification by breaking a rib of a man who had "died" during a surgical operation. Is the bone-breaking really worth trying in such an emergency or was the reported instance a coincidence?

M.D., Tennessee

ANSWER: *By Consultant in Anesthesiology.* Any severe stimulation tends to start breathing severely depressed by a drug. Probably the much better known procedure of dilating the anal sphincter would have done as well.

QUESTION: About six weeks ago a circular area, one-half in. across, developed on the left top of the scalp of a thirteen-year-old boy, a case of alopecia areata. Otherwise, his hair is bushy, somewhat dry, and wiry. He appears normal in every respect and there are no pathologic laboratory findings. The boy is 67 in. tall, weighs 145 lb. Physical examination reveals a slight increase in fat deposit about the mammary regions. His sex organs are normal and he has a fine peach fuzz on face and upper lip. There is no indication of any infectious or fungous process on the scalp. I am giving him 0.5 gr. thyroid. There is no evidence of the condition in other members of his family. How can the condition be improved?

M.D., Missouri

ANSWER: *By Consultant in Dermatology.* The cause of alopecia areata is not known. There is no satisfactory evidence that it results from endocrine disturbance, but indications are increasing that the condition may result from nervous and emotional strains. This, however, is by no means easy to demonstrate.

The changes in this case are probably only those associated with the patient's adolescence. Some physicians treat alopecia areata locally, but I have little or no faith in such therapy. The bald area could be rubbed twice daily with a keratolytic lotion such as 3% salicylic acid in alcohol.

The general hygiene of the patient and the emotional contacts at school and home should be reviewed. In young individuals regrowth should occur within three or four months.

QUESTION: What is the recommended medical management of a pregnant woman who is Rh negative and has had erythroblastic infants? Is there an injectable that is effective?

M.D., California

ANSWER: *By Consultant in Obstetrics.* Rh-negative pregnant women who are wed to Rh-positive men or who have had erythroblastotic infants should have periodic tests made of their blood for presence and titer of Rh antibodies. A rising titer indicates a strong possibility that the infant will be erythroblastotic. Preparations should then be made for transfusions of compatible Rh-negative blood, if

possible of the replacement type, to the newborn. Premature interruption of pregnancy because of a rising titer is of questionable value.

The isolation of a protein-free Rh hapten in 1947 by Carter offers great promise for treatment of the mother to prevent erythroblastosis in the infant and also for definitive therapy in the afflicted newborn. Unfortunately this substance is not yet available commercially. For additional information regarding this hapten refer to the article by Bettina B. Carter in *Journal of Immunology* 61:79, Jan., 1949.

QUESTION: How do the findings differ in early labyrinthitis and in a dead labyrinth?

M.D., New York

ANSWER: *By Consultant in Otology.* Acute labyrinthitis secondary to otitic infection may occur as perilabyrinthitis, localized serous labyrinthitis, diffuse serous labyrinthitis, or diffuse suppurative labyrinthitis.

The presence of objective symptoms and their severity will depend upon the type of labyrinthine involvement. In general, the findings will be nystagmus of rotatory horizontal type with the rapid component toward the diseased ear until the labyrinth is destroyed, whereupon it changes to the normal side. The patient falls toward the normal side (Romberg's test) and past points in the same direction. Hearing loss will be partial to complete. In testing, the normal ear should be masked.

In a dead labyrinth, deafness is complete, with no response to stimulation of the labyrinth by caloric or turning tests. Equilibrium is often disturbed, especially in the dark. This may be compensated for in time by the normal side.

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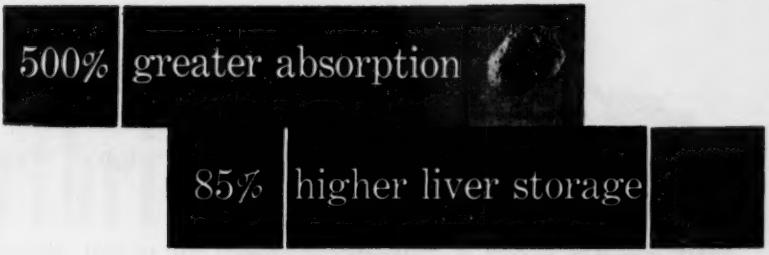

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Forensic Medicine

COMPILED BY ARTHUR L. H. STREET, LL.B.

PROBLEM: The surgeon in charge of a railroad company's hospital allegedly promised to notify an employee-patient's mother of any change for the worse in her son's condition. The surgeon failed to do so, thereby depriving her of the opportunity to be with her son before his death. Was the company liable to the mother in damages?

COURT'S ANSWER: No.

The Texas Court of Civil Appeals decided that the surgeon's promise could not be regarded as a binding contract or as anything more than a personal and gratuitous undertaking on his part to accommodate an anxious mother. The surgeon had no authority to bind the company by any such promise (120 S.W. 1079).

PROBLEM: When two doctors practice as partners, may each assure to the other, by agreement, the right to take over the business alone if one dies, thereby avoiding need for liquidation of the deceased partner's share?

COURT'S ANSWER: Yes.

Many years ago, the U.S. Circuit Court of Appeals, Eighth Circuit, upheld such an agreement in a Missouri case. It was there agreed that on the senior partner's dying or becoming incapable of practicing, the junior partner should take over the business and its assets. The court decided that there was no testamentary disposition of the senior partner's share, in the sense that it must be made in the form of a will or that probate court proceedings must be had before the junior owner could succeed to the business (56 Fed. 409).

This decision was lately referred to in support of the Kentucky Court of Appeals conclusion that partners may validly agree that when one dies the other shall automatically succeed to sole ownership of the business, taking over the assets and paying all firm debts. In that case, it was provided that compensation for the deceased partner's share should be paid to his widow and children in the form of insurance carried on his life for their benefit at partnership expense.

The court ruled that the agreement was binding although the value of the deceased partner's share at his death was more than double the amount of insurance carried by the firm for the benefit of his family (214 S.W. 2d 984).

PROBLEM: Was a conviction of felonious abortion sustainable under the South Carolina statutes in the absence of proof that the woman was quick with child?

COURT'S ANSWER: No.

The South Carolina Supreme Court decided that the local statutes distinguish between cases in which fatal abortion is committed after the woman has become quick with child—a

(Continued on page 37)

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1. MacKee, G. M.; et al.: J. Invest. Dermat. 6: 309 (1945). 2. Osborne, E. D.: Postgrad. Med. 1: 16 (1947). 3. Grinnell, E. D.: Journal-Lancet 68: 121 (1948). 4. Strauss, M. J., and Sigel, H.: Connecticut M. J. 13: 100 (1949).

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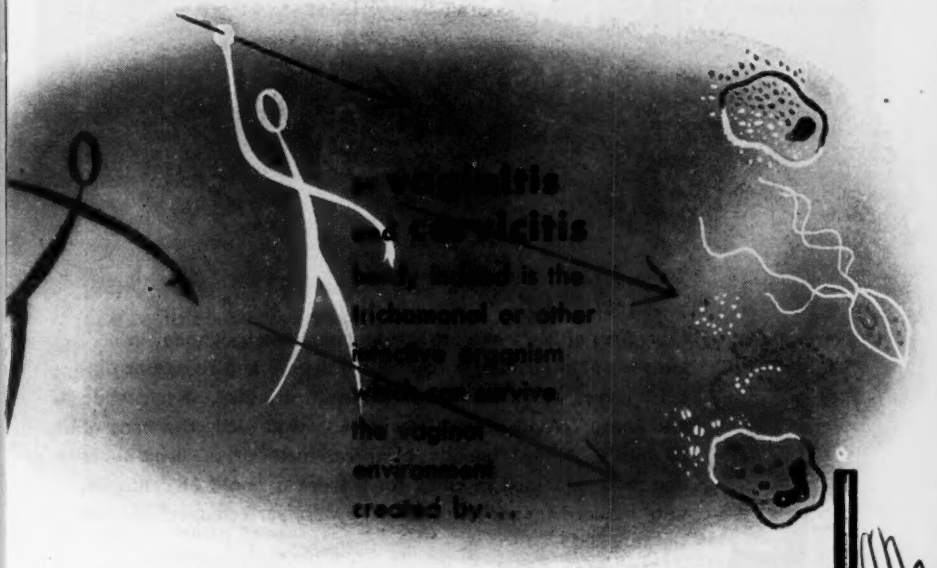

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felony—and cases in which she has not reached that condition and death does not result—a misdemeanor.

The court noted that the abortion was committed within three months after conception and that, within that time, the child has no independent existence (51 S. E. 2d 91).

PROBLEM: Are parents entitled to enjoin public school authorities from requiring their children to be vaccinated as a condition to their being permitted to attend school?

COURT'S ANSWER: No.

The requirement was made pursuant to a rule adopted by the Kentucky State Board of Health, and the Court of Appeals of that state decided that the rule was authorized by local statutes. The court added that the petitioners for an injunction were in no position to attack the school authorities' action, since petitioners had violated a statutory duty to have their children vaccinated.

The opinion cites a decision of the U. S. Supreme Court, to the effect that no constitutional right of children is violated through a vaccination requirement imposed as a condition to being permitted to attend school.

The Court of Appeals also brushed aside the contention of one of the petitioners that to compel him to have his children vaccinated violated his right to religious freedom. The court said that there could be no interference with petitioner's "belief against vaccination, but he may not endanger the health of the community by refusing to have his daughter vaccinated."

The court ruled that vaccination may be compelled although there is no immediate danger of a smallpox epidemic (215 S. W. 2d 967).

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Special Article

How Is the British Doctor Getting Along?

VICTOR COHN

The second of two articles prepared for Modern Medicine

BRITAIN'S doctors are loyally operating their government's new health service with a spirit remarkable among men who so recently fought Labor's health plans.

During five weeks in England and Wales, I talked to city and country doctors, GP's and specialists. "How will this plan work out?" I asked. All but a few answered, "Oh, we'll make it work sooner or later. We've got it now, and we'll work it."

Why this acceptance? One answer is that Britain's doctors had for years agreed in principle on the need for some degree of socialized medicine—although they disliked Labor's program. Then there is the British tradition of order and duty. The British voters have decided upon a course and the doctors are following it.

Still, Britain's doctors by and large are insecure, and many are disgruntled. They fear [1] being underpaid, [2] becoming salaried government employees, and [3] bureaucracy.

"The government never pays enough," one doctor told me. GP's tend state patients for $3 to $3.50 a patient per year. The maximum is usually 4,000 patients, the average 2,200.

The health ministry puts $3.60 a head for 95% of Britain's population into a pool. Special payments, such as auto mileage for country doctors, are subtracted. The remainder is split into regional pools. Some money is taken out to pay basic salaries for certain GP's, plus fees for emergency treatment. What's left is divided according to the number of patients on each doctor's panel.

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KEY

- *Direct responsibility*
- *General supervisory powers*
- *Doctors and dentists will work at Health Centers provided by local authorities*
- *Temporary responsibility— eye services will ultimately be provided by Regional Hospital Boards*
- *Medical Practices Committee will regulate admission to practices within the public service*

Young men in their first three years' practice, and others who successfully apply, get a $1,200 yearly salary, plus a fee-per-patient lower by a seventh. Doctors with small practices often seek this. However, the money comes out of the regional pool, so local committees, which include local doctors, frequently say "No."

On the basic salary a doctor with 2,000 patients will gross $7,264 a year and have $4,360 left if expenses run 40%. A doctor on straight annual fees and with 4,000 on his list will gross about $13,000 before expenses.

GP's can also collect for practicing in "unpopular" areas, supervising assistants, supplying on-the-spot drugs, dispensing drugs, hospital staff duties in small towns, and maternity care. A midwife usually delivers the baby, but the doctor gives pre- and postnatal care for which he is paid $21 or $29.40, according to his qualifications.

Doctors may also serve in local government health clinics or on government or insurance company medical boards. They may work for private firms and may have private patients.

Every doctor contributes 6% of his annual net which, with a government contribution of 8%, goes for retirement pension, death benefits, and widow's pension.

Most doctors report that income is down. The others say they keep income up at the cost of heavy overwork. Some doctors in crowded slums and industrial areas are making more than they ever did before.

Incomes in some generously doctored residential areas are believed down by 50 to 60%. The *Lancet* estimated that GP incomes have dropped a third. Hardest hit are country doctors, who are "shocked to see how small the numbers on their list, how big the fall in their incomes and yet how busy their days remain."

Dr. Thomas D. V. England, Cardiff GP with just over 2,000 state patients, plus an industrial medical job and no private patients, told me: "I get more money in pounds, yes, than I used to. I collect now for people who could pay me nothing before. But my income hasn't gone up with living cost."

In a Welsh coal town Dr. Trevor Bryant said: "Many are hard hit indeed. It's just a raw deal."

The new Fellowship for Freedom in Medicine contends that

many country GP's "border on bankruptcy." It cites Dr. C, with 1,450 state patients and almost no private patients in an area of 150 square miles.

His three-month government check was $1,132, his expenses $500. His loans, overdrafts, and mortgages totaled $28,000, on which he must repay $440 a quarter. That left him $16 a week. He has three children, two at boarding school.

The government has insisted that the income for GP's is up 60% since prewar days and now averages $9,540 a year and that this puts the GP in Britain's top 10%. But expenses are high. One rural doctor calculated his expenditure for drugs, wages, fuel, phone, and car at $6,816 in 1949. The same expenditures ten years ago were $2,544. One cost of living index is up 180% since 1939.

A burden for all is the income tax, which averages 45%. Another is the tradition of sending children to private schools.

The British Medical Association is pressing the government now to increase the central pool for GP's by $66,000,000 a year, allotting the added sum to the first 1,000 patients on each doctor's list. This would aid those with small lists and encourage small lists and better medicine.

In July 1948, when the health service started, the ministry added 34% to the pool for cost of living increase. Today the BMA says the figure should be 85% but will accept 70% because of Britain's strained finances. The BMA argues, too, that the fund was based on an expected force of 17,900 GP's; today, 21,000 participate.

The health ministry is now making a new study of GP incomes. *Lancet*, friendly to the health service but critical of its shortcomings, observes:

> [The general practitioner] must receive broad basic training. He must have ready access to means of diagnosis, as well as contact with the hospital consultant and specialist. He must have opportunity and time, through provision of health centers and increased recruitment, to apply his mind to clinical problems, and he must have suitable pay and prestige, if only to ensure that he is joined by able colleagues. Today not one of these conditions is satisfied.

The 5,000 specialists in the service do better.

The government has agreed to pay what the *Lancet* calls "generous" salaries to specialists serving full time. Incomes from all sources are "almost certain" to reach $8,000 a year by

the time a doctor reaches thirty-two, and $12,000 a year by forty. A few specialists "of special distinction" may receive as much as $21,000 a year.

Specialists on part time get $16.80 a consultation and may also receive salaries for hospital service. Specialists used to donate their hospital work and live by private practice. Now the government has taken over almost all hospitals, and everyone is paid.

In general, specialists told me, established men with profitable pre-plan practices are earning somewhat less than they did, but younger men profit.

Specialists not serving the government full time have kept more private patients than the average GP. However, private practice has dwindled to about 5% for all, and to nearly nothing for some.

Private practice will be years in disappearing entirely. Doctors' offices and hospitals are so crowded that many patients prefer to pay for personal attention or a private room. The private patient's lot is increasingly hard, however. He gets nothing from the state toward hospital bill or drugs. Bed charges have been multiplied four or five times.

"Private practice is practically dead," said one doctor to me. "We'll be full-time civil servants sooner or later."

A few years ago a Conservative member of parliament accused Aneurin Bevan, Labor health minister and declared archenemy of capitalism, of wanting a doctor's civil service "as soon as" he could impose it.

"There is all the difference in the world," Bevan replied, "between plucking fruit when it is ripe and plucking it when it is green."

Doctors recall this when Bevan repeats his promise not to organize a salaried service. He is pledged to ask parliament to prohibit him from ever decreeing one without parliamentary sanction. Yet doctors read Labor party statements like these:

"The Labor party has always been in favor of a salaried service." . . . With a doctor shortage, it is wrong that paying patients "should get more than their rightful share" of time . . . The extent of private practice's survival "after a number of years" will test the plan's "success or failure."

(Continued on page 92)

Management of Hemophilia

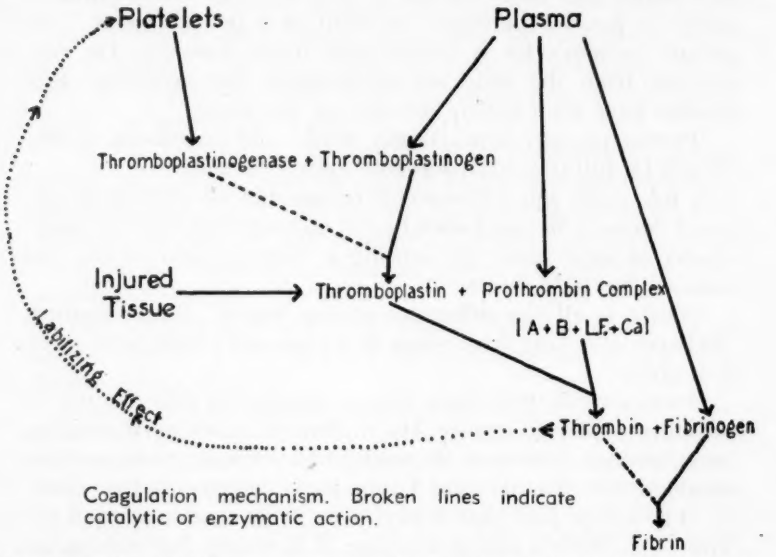
ARMAND J. QUICK, M.D.*
Marquette University, Milwaukee

A HEMOPHILIAC may reasonably expect a long and useful life if injury is avoided, bleeding checked by local and systemic means, and every precaution taken before surgery.

The missing blood factor has now been identified and diagnosis consequently assured.

ing states by symptoms, hereditary trend, and special tests. In addition to coagulation time and prothrombin time, the clotting time of recalcified plasma and prothrombin consumption time are determined.

All factors needed for thrombin formation are usually supplied by plasma except thromboplastinogen-



Coagulation mechanism. Broken lines indicate catalytic or enzymatic action.

The thrombin deficiency responsible for failure to clot arises from lack of thromboplastinogen (see illustration). Armand J. Quick, M.D., delimits hemophilia from other bleedase, an enzyme derived from platelets. This catalytic agent converts thromboplastinogen to active thromboplastin. The latter then forms thrombin by reacting with the prothrombin

* Pediatric aspects of hemophilia. Pediatrics 3:312-317, 1949.

complex, which consists of components A and B, the labile factor and bound calcium.

The greater the amount of thromboplastinogen in plasma, the more prothrombin is converted and the more thrombin is formed. But if thromboplastinogen is deficient, not enough thrombin is available to produce fibrin for coagulation.

Thrombin has the essential task of labilizing platelets. With large quantities of thrombin, thrombocytes disintegrate faster and in turn thrombin forms quickly.

The blood of normal persons thus coagulates in a few minutes but in hemophilic blood the chain reaction never starts; thrombin is insufficient, and platelets remain intact.

Standard texts imply that hemophilia is recognized by bleeding beginning early in life, hereditary tendencies, and prolonged coagulation time.

Most babies, however, are protected from trauma, and bleeding may not be noted for several years.

In over a third of cases inheritance cannot be established, probably because the trait has been transmitted without manifestation through several generations of women. Coagulation time, which must be estimated with venous blood under careful, standardized conditions, may be normal when hemophilia is slight.

The most reliable and useful diagnostic technic is estimation of thromboplastinogen by the prothrombin extent of consumption.

First the blood is allowed to clot and then, an hour later, prothrombin remaining in serum is determined by the one-stage technic.

In coagulation of normal blood, 60 to 90% of prothrombin is consumed, but with hemophilic blood most of the prothrombin is unconverted. Prothrombin consumption time of normal blood serum is usually sixteen to thirty-five seconds and of hemophilic samples nine to twelve seconds.

The clotting time of recalcified plasma complements the ordinary coagulation test.

After rapid centrifugation of oxalated hemophilic blood, plasma takes longer to coagulate than after slower rates of centrifugation, whereas normal recalcified plasma is little influenced by the speed of revolution.

Although hemophilia is probably incurable, crippling effects are often avoided. Immediately after injury, circulation in the damaged area should be retarded by pressure and application of cold. Enough thrombin may then accumulate to form limited amounts of fibrin and prevent bleeding. Application of heat may convert a minor injury into a massive hemorrhage.

When bleeding into a joint or muscle subsides, heat is cautiously applied to hasten resorption. Diathermy, passive exercise, light massage, and eventually active exercise will stimulate circulation and prevent ankylosis.

Before and during every operation, fresh or lyophilized plasma should be given, or twice as much blood for the same objective. Cohn's plasma fraction I is potent but not generally available.

Arterioles and small arteries will contract for several hours after trauma and during this time are more easily plugged with fibrin than is otherwise the case.

Pseudo-Hyperparathyroidism after Peptic Ulcer Therapy

CHARLES H. BURNETT, M.D., ROBERT R. COMMONS, M.D.,
Boston University
FULLER ALBRIGHT, M.D., AND JOHN E. HOWARD, M.D.*
Harvard University, Boston, and Johns Hopkins University, Baltimore

PATIENTS receiving prolonged, excessive milk and alkali therapy for peptic ulcer may develop a syndrome easily confused with hyperparathyroidism.

An elevated serum calcium level, metastatic soft tissue calcifications, and renal insufficiency with azotemia all suggest the presence of excessive parathyroid gland activity with secondary renal damage.

Charles H. Burnett, M.D., Robert R. Commons, M.D., Fuller Albright, M.D., and John E. Howard, M.D., list several characteristics of the syndrome which distinguish it from hyperparathyroidism:

- ► Normal or elevated serum phosphorus concentration
- ► Absence of hypercalciuria and of hypophosphatemia
- ► Lack of skeletal demineralization
- ► Normal serum alkaline phosphatase

Clinical features of the syndrome include a history of peptic ulcer symptoms treated for many years with large quantities of milk and absorbable antacids, such as sodium bicarbonate. Pruritus is often noted. The presenting complaint is usually an exacerbation of ulcer symptoms.

The cornea shows granular deposits around the limbus. These lesions resemble band keratopathy and were found in all of 6 patients studied. In the late stages of the disease the physical findings of uremia predominate.

Roentgenograms may reveal metastatic calcification in the parenchyma of the kidneys, meninges, diaphragm, blood vessels, tendons, cartilage, bronchi, mesenteric lymph nodes, or subcutaneous nodules. The bones are not demineralized and may show periosteal new bone formation.

Kidney function tests indicate severe renal insufficiency. Isosthenuria is present. The nonprotein nitrogen of the blood is elevated. Phenolsulfonphthalein excretion and urea clearance are depressed. Some degree of albuminuria is usually found.

However, other blood abnormalities differ from those usually seen in uremia from chronic Bright's disease. The serum calcium is elevated, a tendency to alkalosis develops, and the plasma proteins are often increased.

Treatment consists of reducing the intake of milk and absorbable alkali.

* Hypercalcemia without hypercalcuria or hypophosphatemia, calcinosis and renal insufficiency. New England J. Med. 240:787-794, 1949.

A high fluid intake should be maintained. Subjective improvement will occur and the blood nonprotein nitrogen concentration decreases. The serum calcium and phosphorus both diminish after therapy, suggesting that the high phosphate content of milk as well as the milk calcium is a factor in the production of the pseudo-hyperparathyroid syndrome.

Retinal and Vascular Damage in Diabetes

J. HALLIDAY CROOM, M.B., AND G. I. SCOTT, M.B., EDINBURGH*

EVEN as late as twenty-six years after onset of diabetes, vascular and retinal complications are not inevitable. At Royal Infirmary, Edinburgh, J. Halliday Croom, M.B., and G. I. Scott, M.B., found that 15 of 60 patients with long-standing diabetes were free from degenerative disease.

Diabetic retinopathy sometimes occurred without signs of hypertension or generalized arteriosclerosis. In most instances arteriosclerotic changes in the retinal vessels were slight or absent and half of the patients with retinopathy had normal retinal arteries.

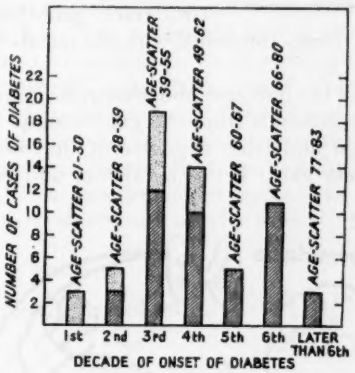


Fig. 1. Age distribution of 60 diabetics. Hatched columns indicate presence, stippled columns absence of vascular complications in relation to decade of onset of diabetes.

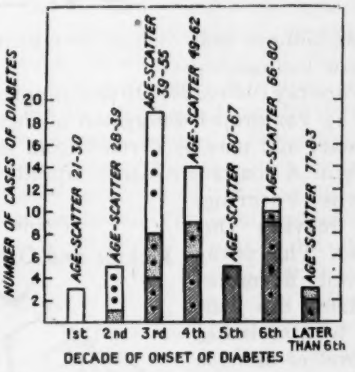


Fig. 2. Relation of retinopathy to blood pressure. Blank columns indicate normal blood pressure; stippled, doubtful; and hatched, raised. Each dot signifies 1 case.

A nephrotic syndrome, evidence of diabetic intercapillary glomerulonephritis, appeared in only 2 cases.

Vascular or retinal changes could not be correlated with the severity or the control of the diabetic stage.

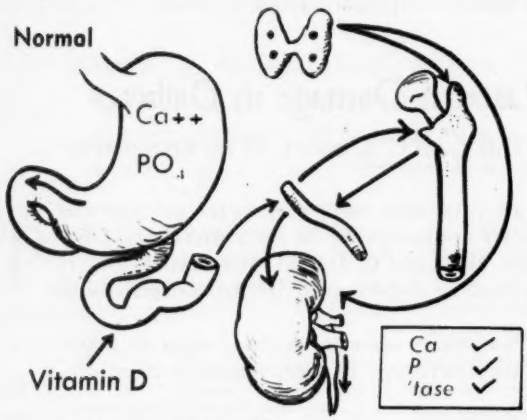
* Retinal and vascular damage in long-standing diabetes. Lancet 256:555-558, 1949.

Calcium and Phosphorus Metabolism in Disease

L. W. KINSELL, M.D.*

University of California, San Francisco

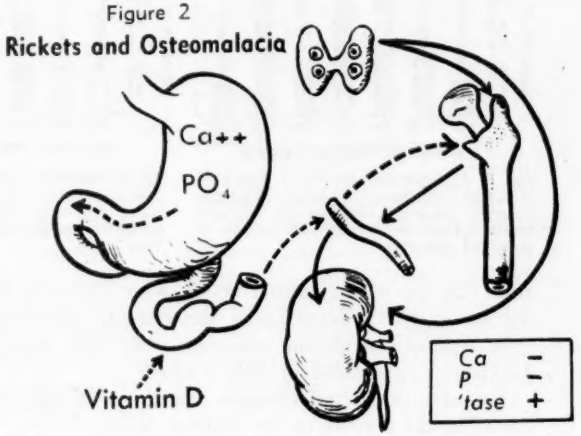
Figure 1



KNOWLEDGE of the normal and abnormal metabolism of calcium and phosphorus in the human body greatly facilitates the diagnosis and treatment of many diverse and important diseases. Laurance W. Kinsell, M.D., lists the digestive tract, parathyroid glands, kidneys, and bones as the organs chiefly concerned with the metabolism of these two minerals.

In healthy individuals dietary supply of calcium and phosphorus is adequate (Fig. 1). For proper absorption of these minerals from the gut, vitamin D is necessary and may be derived from food and from exposure of the skin to sunlight. A constant dynamic equilibrium exists between calcium and phosphorus entering and leaving the bones. The parathyroid hormone regulates this balance by stimulating removal of mineral from bone and by inhibiting the renal tubular reabsorption of inorganic phosphate from the glomerular filtrate.

Figure 2



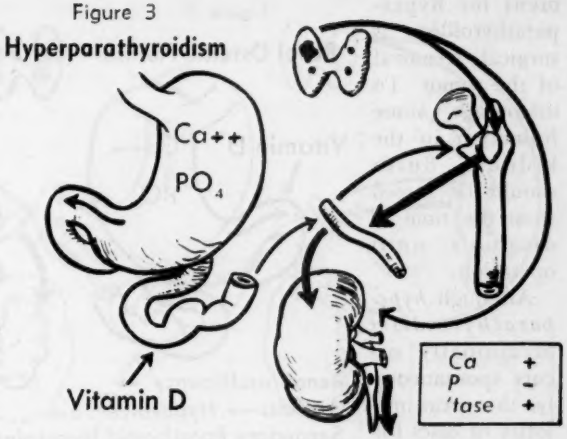
The normal serum level of calcium, 9 to 11 mg. %, and phosphorus,

* A consideration of calcium and phosphorus metabolism, including the normal and pathologic physiology of the parathyroid glands. Am. Pract. 3:499-505. 1949.

3 to 4 mg.%, is adjusted chiefly by the above factors. The serum alkaline phosphatase reflects mineral activity in bones and is higher in children than in adults: adults, 2 to 5; children, 5 to 15 Bodansky units.

Rickets appears in children and *osteomalacia* in adults when insufficient calcium and phosphorus are absorbed from the gut (Fig. 2). The cause may be dietary deficiency of these substances or lack or vitamin D from food and skin. The serum calcium is decreased, resulting in compensatory parathyroid hyperplasia which leads to demineralization of bone. Excess parathyroid hormone also lowers the serum phosphorus level by blocking renal reabsorption of phosphate. Increased osteoblastic activity often elevates the serum alkaline phosphatase.

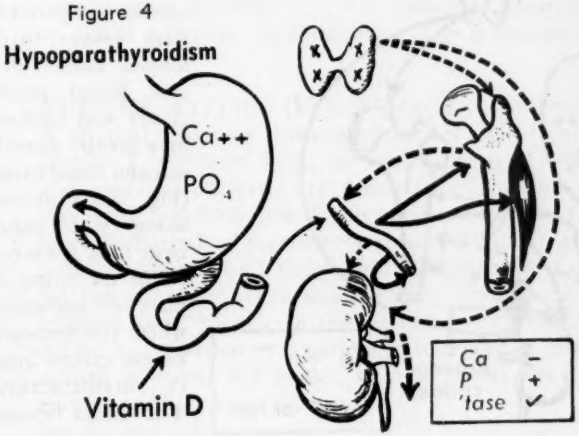
Figure 3



Treatment is determined by the initial deficiency and may include administration of calcium, phosphorus, and vitamin D.

In *hyperparathyroidism* osteoclastic demineralization of bone is increased, sometimes with cyst formation (Fig. 3). Phosphate reabsorption by the tubules is decreased, reducing the serum phosphorus. The serum calcium and usually the alkaline phosphatase are elevated. The increase in urinary excretion of calcium and phosphorus may lead to precipitation of calcium phosphate as stones in the renal parenchyma or renal pelvis. Hyperparathyroidism should be considered a possible cause of all renal stones.

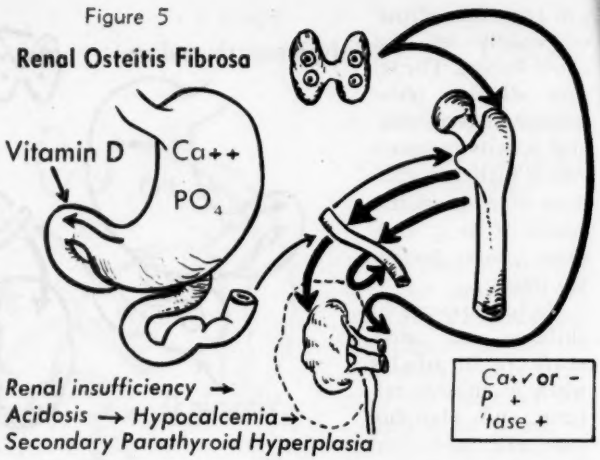
Figure 4



The only treat-

ment for hyperparathyroidism is surgical removal of the tumor. To discourage stone formation in the kidneys, fluids should be forced from the time of diagnosis until operation.

Figure 5

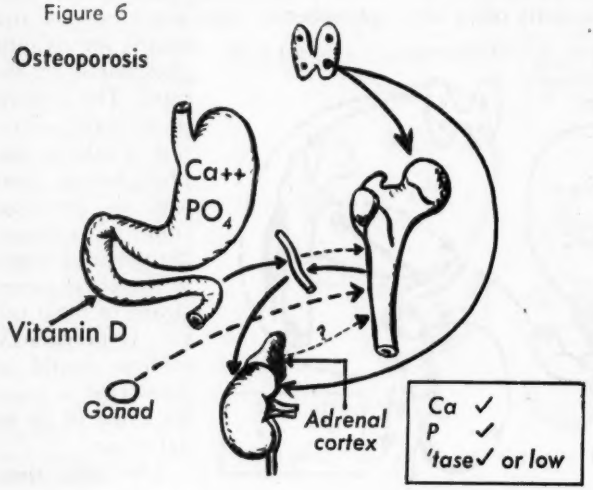


Although *hypoparathyroidism* occasionally occurs spontaneously, the great majority of cases follow thyroid gland surgery. Calcium and phosphorus are deposited in the bones in the usual manner, but the lack of parathyroid hormone inhibits mobilization of these minerals (Fig. 4). In addition phosphate excretion in the urine is decreased.

The resulting chemical changes are high serum phosphorus, low serum calcium, and consequent tetany, the principal symptom of hypoparathyroidism, which is often misdiagnosed as epilepsy.

Treatment is designed to elevate the serum calcium level, by 1 to 1.5 mg. of dihydrotachysterol or 2 to 5 mg. of calciferol daily.

Figure 6

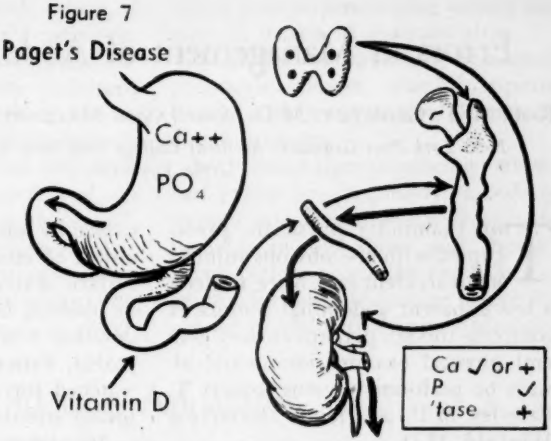


Renal osteitis fibrosa occasionally occurs in patients with severe, prolonged kidney disease. Renal insufficiency and acidosis may greatly disturb calcium metabolism (Fig. 5). Calcium, along with other basic ions, is excreted in the urine in place of ammonia, which the damaged kidney can no longer manufacture. The bones become

demineralized and the serum calcium level falls, producing compensatory hyperplasia of the parathyroids.

Therapy is directed toward correction of the acidosis by administration of base, including calcium. Because of associated kidney disease, the prognosis is poor.

Figure 7



Osteoporosis is a disease of the bone matrix, not primarily a defect of mineral metabolism, and occurs in postmenopausal women and, less frequently, in old men. The cause probably is deficiency of adrenocortical or gonadal hormones necessary for protein anabolism (Fig. 6). Formation of the matrix of the bone is impaired.

Back pain is the usual complaint. Roentgenograms of the spine are helpful for diagnosis. The vertebral bodies are narrowed, demineralized, and may have compression fractures.

The blood calcium, phosphorus, and phosphatase are all normal in this condition.

Treatment consists of a high-protein, high-vitamin diet supplemented with 0.05 mg. of ethinyl estradiol per day and sublingual administration of 10 mg. of methyl testosterone daily.

Paget's disease is the result of increased catabolism of bone in localized areas and occurs chiefly in old men (Fig. 7). Skeletal deformities and renal stones are common. The serum alkaline phosphatase is high. The etiology is obscure. No therapy is known.

POSTHEPATITIC LIVER DAMAGE is apparently not related to physical activity or drinking of alcohol after the attack of hepatitis. Horace T. Gardner, M.D., of Yale University, New Haven, Conn., and associates observed 114 American soldiers for six months to a year after hospitalization for infectious hepatitis. Of these, 68 had been discharged as presumably cured; the other 46 had had slight residual abnormalities. Only slight differences were observed between the two groups on reexamination after the interval. Relatively more residuals were present in the presumably cured men than in the others. Examination with particular reference to interim activity and alcohol indicated that neither of these factors was related to appearance of residual abnormalities.

Ann. Int. Med. 30:1009-1019, 1949.

Errors in Management of Abdominal Injury

ROBERT T. CROWLEY, M.D., AND JAMES MACFARLANE WINFIELD, M.D.*
New York Post-Graduate Medical College and New York Medical College, New York City

THE examining physician, preoccupied with the obvious injuries in an accident case, often neglects a less apparent abdominal trauma. A complete though perhaps cursory general physical examination should always be performed, warns Robert T. Crowley, M.D., and James Macfarlane Winfield, M.D.

When possibility of abdominal injury exists, therapy should be carried out exactly as if such trauma had been diagnosed.

Exploratory laparotomy should be done when severe visceral damage is suspected after a period of close observation and treatment. Far better to risk laparotomy, even if nothing serious is found, than miss intraperitoneal hemorrhage or spreading peritonitis because of excessive caution.

Penetrating abdominal wounds are usually easier to evaluate than nonpenetrating, because the damage is ordinarily apparent. However, seemingly superficial penetrating wounds may be deep and involve extensive hidden injury, often far from the site of entrance.

Probing is useless and dangerous. Little information is gained and the probe may start fresh hemorrhage, break important sealed tissue barriers, introduce infection, and create false tracks.

Nonpenetrating injury is usually caused by forcible contact with a large object of broad, smooth, or irregular surface. External skin abrasions may be obvious, but severe, even fatal, abdominal injury is often entirely concealed. Patients must be continually watched for signs of increasing peritoneal irritation or hemorrhage.

All abdominal viscera are subject to shock and hemorrhage from trauma. However, copious and prolonged bleeding is most characteristic of the spleen, liver, and kidneys and may recur after long periods of arrest. Death due to exsanguination from these organs has occured ten days after injury.

The hollow viscera are less prone to damage when partially or completely empty. If filled, even with fluid or air, the force of the trauma is transmitted to all parts of the contained viscus. When rupture occurs the break is at the weakest point, which may be remote from the application of force. Motility of the viscera likewise influences the site of damage. Motile organs move readily with the blow while the attached parts remain relatively stationary, and tear results. Preexisting disease may also make some viscera particularly vulnerable.

The following considerations are important in diagnosing abdominal injury:

► Contents discharged from viscera tend to drain along the pericolic gut-

* The diagnosis and management of abdominal injury. S. Clin. North America 29:389-397, 1949.

ters and pool in the pelvis, where, if copious, detection is possible by examination. When contents of stomach or small intestine are rapidly discharged into the free peritoneal cavity, the inflammatory reaction is usually immediate and severe. Signs are less swift with gradual leakage. Intraperitoneal reaction to contents of large bowel, gallbladder, or bladder develops slowly.

► Free air in the peritoneal cavity is evidence of rupture or perforation of the stomach, small bowel, or colon, unless a large penetrating wound has allowed ingress of external air.

► Reflex inhibition of intestinal peristalsis almost always appears shortly after severe injury of intraabdominal viscera.

► Physical signs suggesting abdominal injury are frequently caused by trauma to extraabdominal areas, particularly in the spine and thorax. These regions should be carefully examined for possible damage before diagnosis of abdominal injury is made.

Suction Apparatus

K. Alvin Merendino, M.D., and John A. Phelan*

A machine for applying suction to tubes in the gastrointestinal canal, described by K. Alvin Merendino, M.D., of the University of Washington, Seattle, and John A. Phelan of the Scientific Apparatus Shop of the University of Minnesota, Minneapolis, insures safety to the patient and conserves expense and nursing time.

The apparatus, which may be attached to several tubes at once, consists of a hand pump enclosed in a welded steel tank. Inexpensive standard parts, available at any automobile accessory shop, are used.

The pump cylinder is a heavy walled brass tube with a check valve of oilproof neoprene at the bottom. The pump leather is fastened to the bottom of the pump rod in such a way that it cannot become loose or unscrewed. The pump assembly can be taken apart for repairs.

On top of the tank are a single orifice needle valve, a negative pressure gauge graduated in inches of mercury, and a conduit. Rubber tubing connects the conduit to a catch basin and then to the patient.

Operation of the machine requires little time. With the needle valve closed, twenty-five to thirty light strokes of the pump are sufficient to evacuate the tank and create enough suction to drain approximately 4 gal. of material from the patient. The nasal tube is connected to the catch bottle and the needle valve closed. Bottle and tube are immediately evacuated.

Suction cannot become excessive, because the force is gradually exhausted as the apparatus functions. The construction of the system also prevents influx of air and fluid into the stomach.

* A new, safe, simple apparatus for obtaining negative suction for the patient with an indwelling gastrointestinal tube. Surgery 25:576-579, 1949.

Mechanism of Deformity in Scoliosis

ALVIN M. ARKIN, M.D.*
New York University, New York City

WEDGE-SHAPED distortion of vertebrae occurs with scoliosis when epiphyseal growth is checked on one side by uneven pressure of the spine. The deformity can therefore develop only in youth. Alvin M. Arkin, M.D., believes that adolescent kyphosis may result from a similar process.

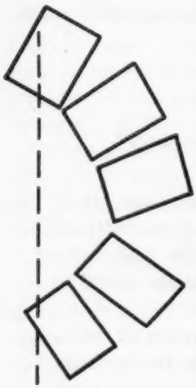


Fig. 1

Pressure on the vertebral column resembles the action of weight bearing down on a stack of blocks (Fig. 1). In a scoliotic curve the concave sides of the vertebral bodies are compressed and convex sides spread apart. Intervertebral disks are narrowed on one edge and expanded on the other.

Extreme compression centers on a very small section of the epiphyseal plate. Forces acting on a vertebra at the apex of the curve are shown by a diagram (Fig. 2), where x is the distance from the line of gravity to the near edge of the disk and y the distance from the pivot or fulcrum of the vertebra to the ligament on the outer edge. The total weight concentrated upon the fulcrum equals the superincumbent weight plus the same weight times x/y.

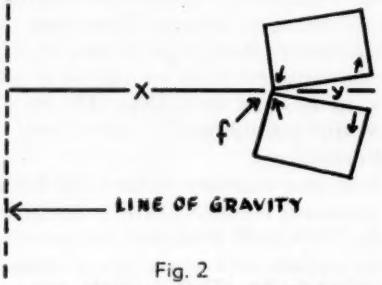


Fig. 2

Fig. 3

Fig. 4

A well-aligned vertebra is supported at four points, *A*, *B*, *C*, and *D* (Fig. 3), and lateral bending occurs through the axis *AD*. If support *A* is depressed, bending takes place through *BD* and the concavity of the curve is pushed forward as well as sideways, producing kyphoscoliosis.

Rotation of the spine is due to several factors. A wedged vertebral

* The mechanism of the structural changes in scoliosis. New York State J. Med. 49:495-499, 1949.

body under pressure is squeezed over to the convex side (Fig. 4, top), and one body may actually rotate across the one adjacent. Much twisting results from torsion within the vertebra against the resistance of the posterior articulations.

But the spinous process is also bent toward the concave side by external forces in soft tissue (Fig. 4, bottom). The tips of the spinous processes are connected by the interspinous and supraspinous ligaments. When strained by kyphoscoliosis, the ligaments tend to straighten out the curve (Fig. 5). Moreover, the long spinal muscles on the convex side tend to push and on the concave side to pull the spinous projections into a straight line.

Extra compensatory curves may prevent actual vertebral deformity by scoliosis or arrest a process already begun. In the attempt to level the pelvis and head, the ends of a single major curvature are bent back (Fig. 6). As the spine begins to recurve, compression of the disks starts on the concave side (*d* and *f*).

Vertebrae are wedged and growth inhibited at *f*, and the functional curve thus becomes a structural deformity (Fig. 7).

However, many functional curves without changes in vertebral shape also have purely functional counter

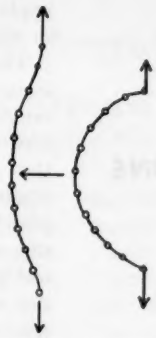


Fig. 5

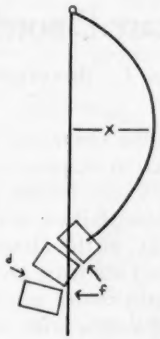


Fig. 6

Fig. 7

curves. Deviation from the weight-bearing line is not sufficient to cause wedging, and the well-compensated deviation is static.

Structural scoliosis too may be arrested spontaneously by natural development of compensatory curves. Treatment designed to aid the process is the chief method of correction, since the wedge-shaped vertebra cannot be altered.

Compensation diminishes *x*, the distance from the line of gravity to the disk, therefore the weight acting on the corner of the vertebral body and pressure on the epiphysis. With both sides of the epiphysis growing, deformity becomes no worse. In one type of treatment the spine is forcibly recurved to wedge the vertebrae at *f*.

In the healthy spine, natural anteroposterior curves in cervical and lumbar regions protect the vertebral bodies by shifting weight from the anterior parts to posterior articular facets. The danger zone for scoliosis is the region from the second thoracic to the second lumbar vertebra (Fig. 8).

When the *x* distance is increased by postural kyphosis, excessive weight is thrown on the dorsal vertebral bodies. Epiphyseal rings, which appear when the child is about fourteen years of age, may be compressed and adolescent

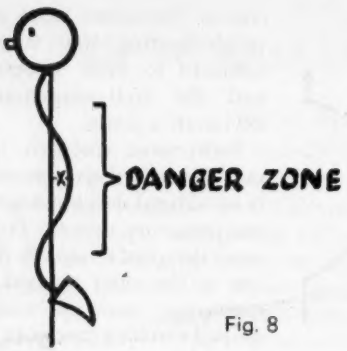


Fig. 8

kyphosis will consequently develop in time.

The best treatment of spinal deformity is obviously preventive: Postural deviations should be corrected before structural changes occur. When the curve is already pronounced, plaster jackets and braces cannot completely relieve the tremendous pressure of weight augmented by mechanical factors. Recumbency does remove the weight and should also be employed.

Procaine for Heart Disorders of Anesthesia

CHARLES L. BURSTEIN, M.D.*

SUDDEN cardiac death on the operating table may be prevented by rapid intravenous injection of procaine hydrochloride. The drug may be administered at any time during general anesthesia or whenever signs of impending heart failure develop.

Charles L. Burstein, M.D., of the Hospital for Special Surgery and New York University, New York City, gives 100 mg. in a 1% solution prophylactically to all adults under general anesthesia, regardless of the heart condition. Tachycardia with hypertension or bradycardia and hypotension may be corrected within a minute or less of administration.

Common anesthetic agents such as chloroform, ethyl chloride, and cyclopropane depress the central nervous system but sensitize the cardiac conducting mechanism. Procaine stimulates the central nervous system and decreases irritability of the heart.

Therapeutic doses of quinidine, morphine, and other drugs prevent cardiac disturbance but may be deleterious. The effective amount of procaine is one-tenth of the tolerance dose and perfectly safe. In many cases an already diseased heart appears to improve by the anesthetic procedure.

Intrathoracic surgery in particular is likely to seriously derange the cardiocirculatory mechanism. To detect complications not shown by ordinary methods, the instantaneous recording electrocardiograph should be included in the anesthetist's equipment.

* The utility of intravenous procaine in the anesthetic management of cardiac disturbances. Anesthesiology 10:133-144, 1949.

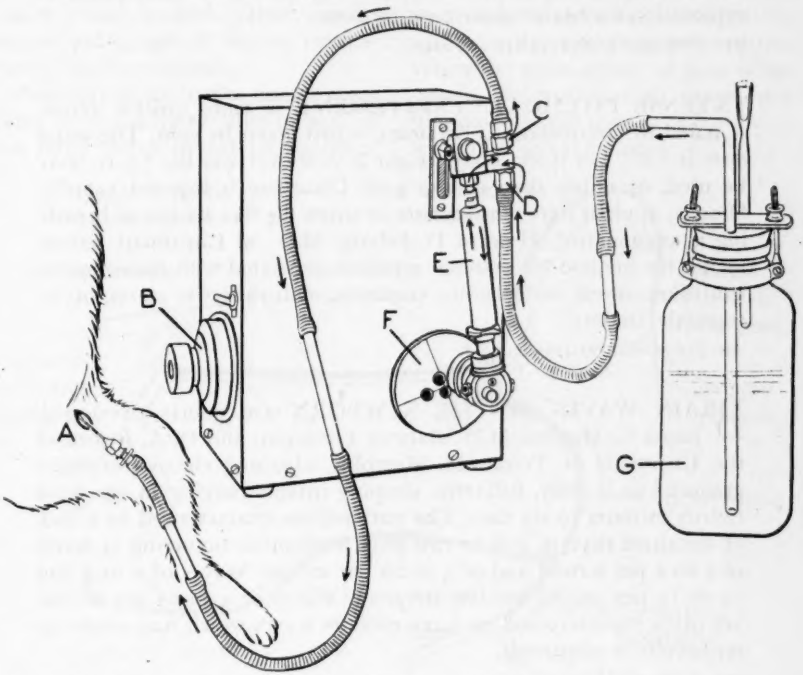
Continuous Arterial Infusion

S. STANLEY SCHNEIERSON, M.D., AND LESTER BLUM, M.D.*
Mount Sinai Hospital, New York City

BONE marrow can be continuously flooded with an antibiotic by a motor-driven syringe connected by tubing with the nutrient artery. Technic is little more complicated than for intravenous infusion.

By giving 200,000 units of penicillin in half an hour, S. Stanley Schneierson, M.D., and Lester Blum, M.D., obtained penicillin concentrations of 11 to 20 units per gram of marrow in dog femurs, whereas intravenous infusion produced a value of less than 1 unit.

The Brewer automatic pipetting machine was used in pumping solutions against strong intraluminal pressures. The apparatus consists of a replaceable syringe *(E)* mounted on a motor-driven cam mechanism *(F)* which transfers fluid from a glass container *(G)* into the artery *(A)* by an



* A method of continuous arterial infusion. Surgery 25:30-35, 1949.

intake *(D)* and output *(C)* valve assembly (see illustration).

Volume is regulated by the speed, under control of a rheostat *(B)*, by the size of the syringe, and by the length of each stroke, as determined by the cam setting. Small needles are preferred. If a small syringe is employed flow is started by air bulb.

For infusion of a dog femur the needle was inserted through the exposed femoral sheath into the artery in a cephalad direction. With a 3-cc. Luer-Lok syringe, the machine was adjusted to deliver 0.5 cc. per thrust every two seconds. This arrangement injects 15 cc. per minute and 500 cc. in about half an hour.

POLYCYTHEMIA AND PAPILLEDEMA are sometimes interrelated. The papilledema, however, may be mistaken as a sign of brain tumor. Therefore neurologic study of all patients with polycythemia is important, declare Morris Axelrod, M.D., and Samuel Epstein, M.D., of Coney Island Hospital, Brooklyn. Examination of visual fields, electroencephalography, and ventriculography are required to exclude an expanding intracranial lesion. If cerebral manifestations progress despite adequate control of the polycythemia, exploration for brain tumor must be done.

New York State J. Med. 49:939-942, 1949.

INTENSE PSYCHOTIC EXCITEMENT is more quickly terminated by electroshock if coramine is first given by vein. The usual dose is 5 cc., but if the body weight is well over 200 lb., 7.5 cc. may be used, or if less than 90 lb., 3 cc. Coramine is injected rapidly. Shock is applied sixty seconds later or when the face flushes or breathing is augumented. Howard D. Fabing, M.D., of Cincinnati recommends the method for extreme agitation associated with mania, acute confusion, severe melancholia, paranoia, schizo-affective states, or intractable anxiety.

Am. J. Psychiat. 105:435-438, 1948.

BRAIN WAVES OF THE NEWBORN are poorly developed. James G. Hughes, M.D., Babette Ehemann, and U. A. Brown of the University of Tennessee, Memphis, obtained electroencephalograms of 72 healthy, full-term, sleeping infants ranging in age from twenty minutes to six days. The patterns are characterized by a lack of sustained rhythm and by two peak frequencies occurring in waves of 1 to 2 per second and of 5 to 10 per second. Waves of 2 to 4 and 11 to 14 per second are less frequent. Waves of 5 to 14 per second are often superimposed on large random waves which may attain 50 microvolts in amplitude.

Am. J. Dis. Child. 76:503-512, 1948.

Geniculate Ganglion Pain

OTHO B. ROSS, JR., M.D.*
Duke Hospital, Durham, N.C.

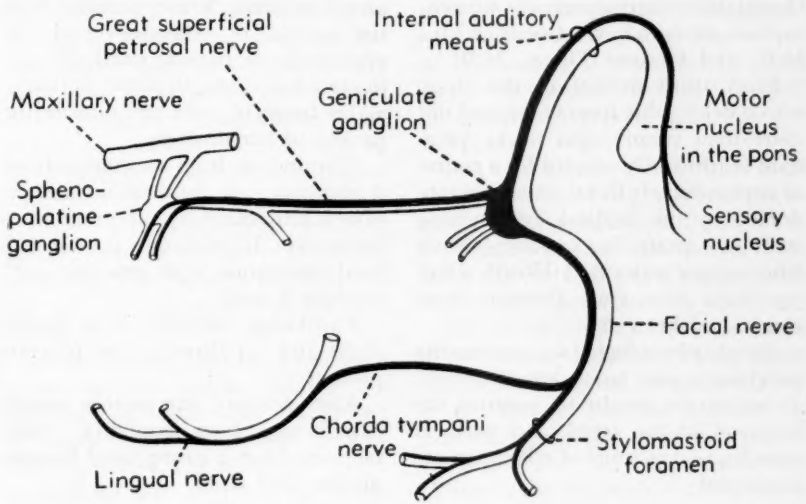
A DULL, constant, deep-seated ache in the eye, temple, cheek, and ear with sharp flare-up for hours or days may arise from the geniculate ganglion. Otho B. Ross, Jr., M.D., has noted instances after Bell's palsy and during or after attacks of herpes zoster.

The condition is uncommon and difficult to recognize because the existence of the small but important sensory component of the facial nerve which connects with other cranial nerves and ganglia is seldom remembered (see illustration).

Pain may be limited to one or more parts of the sensory distribution of the facial nerve or extend to other cranial nerves. Geniculate neuralgia is simulated by tumors, mastoiditis, middle-ear disease, and other lesions, and by psychotic disturbance.

Remedies are usually empirical and supportive. Postherpetic symptoms may be relieved by high voltage roentgen therapy. Pain lasting many years has been known to subside spontaneously.

For severe prolonged involvement the sensory portion of the seventh nerve may be sectioned intracranially with or without other nerve branches. When the exact source of pain is uncertain, several cranial nerves are stimulated at the time of operation to reproduce the symptoms.



* Geniculate ganglion pain. North Carolina M. J. 10:114-117, 1949.

Natural Childbirth

FREDERICK W. GOODRICH, JR., M.D., AND HERBERT THOMS, M.D.*
Yale University, New Haven, Conn.

THE aim of modern obstetric practice should be to make childbirth emotionally satisfactory as well as physically safe.

When delivery is experienced naturally, without deep anesthesia, a happy mother-child relationship is established from the moment of birth and the foundations of good mental health are laid in earliest infancy.

The mother's psychic needs are being realized through classes held in the prenatal clinic of the Grace–New Haven Community Hospital to instruct pregnant women, explain Frederick W. Goodrich, Jr., M.D., and Herbert Thoms, M.D.

Every third patient in the clinic who is deliverable from below and not more than twenty-eight weeks' pregnant is arbitrarily selected for a course of approximately five short classes conducted by the medical and nursing staff. The group also includes women who request natural childbirth. Over 550 have now gone through these classes and been delivered.

Simple physiologic facts concerning pregnancy and labor are described. Exercises are taught to improve the function of the trunk and perineal muscles, and technics of relaxation are explained.

Questions are encouraged and a general atmosphere of informality and reassurance prevails. Anxieties arising from misinformation, ignorance, and superstition are replaced by knowledge of the process of labor.

Group instruction and discussion very often yield greater reassurance and confidence than can be derived from similar individual instruction.

Women receiving the maximum benefit from the classes enter the hospital with the conviction that the experience of labor is completely natural. Nurses familiar with the technic of relaxation and the philosophy of natural childbirth are in attendance; the physician in charge makes frequent visits and informs the patient of her progress.

Appropriate drugs are administered if necessary, but the need for medication is minimized by the program of instruction. If episiotomy is indicated, local infiltration with procaine 0.5% solution is used.

Third-stage bleeding is ordinarily slight and expulsion of the placenta prompt.

After delivery, the mother usually experiences deep euphoria, which helps establish a strong bond between mother and child.

* A commentary on natural childbirth. Pediatrics 3:613-616, 1949.

Hyperthyroidism in Children

ELMER C. BARTELS, M.D.*
Lahey Clinic, Boston

A CHILD who becomes unaccountably nervous and unruly should be examined for toxic goiter. The fact that hyperthyroidism does occur at early ages is too often overlooked and treatment inexcusably delayed.

Among 1,000 consecutive patients treated for hyperthyroidism at the Lahey Clinic were 12 patients between six and fifteen years of age, 11 girls and a boy.

New antithyroid drugs have revolutionized therapy for both young and adult patients. Elmer C. Bartels, M.D., obtains best results with thiouracil and iodine combined, followed by subtotal thyroidectomy in one stage.

The first symptoms of glandular disorder in children are restlessness, irritability, and a voracious appetite with little change in weight. Growth is likely to be rapid and the affected child becomes exceptionally tall. Height may increase as much as 4 in. in six months in contrast to the usual 2 in. per year.

Parents often notice increased body warmth and a palpably overactive heart beat. Occasionally nocturia and bed wetting commence with onset of disease.

As the thyroid disorder continues a goiter becomes visible, though not overlarge in most cases. If proper treatment is neglected, basal metabolism accelerates. The mean rate for the 12 children was +39 and the range +21 to +63. Pulse rates averaged 124 and pulse pressure 70 mm. of mercury.

Symptoms had been present for two months to four years and as a rule were originally attributed to nervousness. In 6 instances iodine was given without success for periods up to eighteen months.

No type of medication produces lasting remission but antithyroid drugs restore good physical condition before surgery. Doses comparable to the adult allowance lower the basal metabolic rate approximately 1% a day without causing myxedema. Optimum daily ration of thiouracil is 600 mg. and of propylthiouracil 200 mg.

In addition, 10 drops of Lugol's solution per day should be administered but only for the last three weeks of medication. If the goiter is fairly large, overdosage with iodine will either delay or prevent a drop in metabolism.

In a typical case, a child with basal metabolic rate of +34 received thiouracil for thirty-six days and iodine for the final twenty-one days. Before operation the metabolic rate was +8 and weight gain amounted to 11 lb.

Should the child appear myxedematous during treatment the blood should be examined for excess cholesterol, even if the metabolic rate is normal. Cholesterol level may rise to 400 mg. or more with a metabolic rate of zero. In 2 instances thyroidectomy

* Hyperthyroidism in children. Lahey Clin. Bull. 6:68-72, 1949.

with hypofunction caused so much respiratory difficulty that tracheotomy was necessary.

Subtotal thyroidectomy should be done in every case. Regardless of the euthyroid state and apparently good heart condition, the pulse rate during anesthesia often varies between 100 and 140.

Primary hyperthyroidism, or exophthalmic goiter, was noted in 11 cases of the series and strumitis in 3. The average duration of treatment was fifty-one days and the range four to eleven weeks. Basal metabolic rates were reduced to +16 or less and pulse rates to an average of 90.

The postoperative condition is known to be excellent in 8 cases. Goiter again developed in 2; in 1 case control is achieved with a daily dose of Lugol's solution.

Gastric Suction after Cesarean Delivery

SYDNEY S. GELLIS, M.D., PRISCILLA WHITE, M.D., AND WILLIAM PFEFFER, M.D.*

RESPIRATORY distress frequently appears some hours after an apparently healthy baby has been delivered by cesarean section. Regurgitated and inhaled amniotic fluid, unusually copious with cesarean birth, is probably the cause. This delayed reaction may therefore be prevented if suction of the baby's stomach is always begun immediately after cesarean operation, believe Sydney S. Gellis, M.D., of Harvard University, Priscilla White, M.D., of Tufts College, and William Pfeffer, M.D., of Children's Hospital, Boston.

Of infants delivered by section, those of diabetic mothers had an average gastric contents of 20 cc.; those of nondiabetic mothers, 14 cc. Infants of nondiabetic mothers delivered by low forceps had only about 2 cc.

Of 50 cesarean infants of diabetic mothers, 25 had gastric suction at once. Of these, 4 had difficult breathing at birth, but none had delayed respiratory obstruction. Of the 25 not given suction, 15 had breathing disorders, 6 at birth and 9 within several hours.

Suction is done within two minutes of birth by a No. 10 French catheter passed slowly through the mouth with constant negative pressure from a resuscitator. After the stomach is reached, the abdomen is gently pressed. Suction is applied during withdrawal.

Oxygen is given for one- or two-minute periods and repeated two or three times until no fluid is obtained. The baby is put in an incubator with flowing oxygen. The nasopharynx is aspirated when necessary; gastric suction is repeated every three hours for twelve hours.

* Gastric suction: a proposed additional technic for the prevention of asphyxia in infants delivered by cesarean section. New England J. Med. 240:533-537, 1949.

Abnormal Micturition

S. Richard Muellner, M.D., and Felix G. Fleischner, M.D.*
Beth Israel Hospital, Boston

Urination becomes automatic whenever muscles of the pelvic floor are immobilized, whether by flaccid paralysis or by disease such as tumor.

The act of voiding is then taken over by the detrusor, which contracts spontaneously when filled to the point of critical stretch. The bladder will empty fairly well if not damaged by overdistention and scar tissue or blocked by urethral stricture.

The goal of therapy for patients who have lost voluntary control is to maintain practically normal capacity with little residual urine in order to prevent frequency. Need of tidal drainage or other measures is determined by status of the voluntary mechanism, detrusor muscle fibers, and urethral resistance to outflow.

S. Richard Muellner, M.D., and Felix G. Fleischner, M.D., studied the physiology of voluntary and automatic micturition in men and women. As shown by fluoroscopy with contrast medium, the flow is started by deliberate relaxation of the pubococcygeus, a large paired striated muscle with voluntary nerve supply.

At the same time, pressure is exerted by brief contraction of the diaphragm and abdominal muscles. Just after the internal sphincter is pushed down, the detrusor contracts centripetally. As the bladder empties the internal sphincter gradually rises. Urinary flow can be stopped at will by contraction of the levator ani, including the pubococcygeus, which pulls the bladder base suddenly upward.

The voluntary mechanism is completely inhibited by prostatic cancer, fixing the gland in the pelvis so that the bladder base can be neither lowered nor raised. Bladder nerves may be intact.

In a case of this type, urine was voided under great urgency about every two hours, day and night. Yet with 6 oz. of urine in the bladder, only a drop or two could be expelled.

Under the fluoroscope the bladder was filled with contrast medium and the detrusor gently expanded. When contents were increased to 8 oz. a point of critical stretch was reached, the detrusor abruptly contracted, and all the fluid was voided into a gravity tube above the bladder level, against pressure of 40 mm. mercury.

The membranous urethra and external sphincter were entirely free of tumor, yet during urination the stream could not be stopped voluntarily. The detrusor would at no time contract when the bladder contained less than the critical amount.

The bladder was again filled, but at the 8-oz. level the catheter was quickly withdrawn. Although the detrusor again contracted, the cancer-

* Normal and abnormal micturition: a study of bladder behavior by means of the fluoroscope. J. Urol. 61:233-243, 1949.

surrounded urethra formed such a poor outlet that only 2 oz. could be expelled. The detrusor then relaxed.

In this case frequency of urination was determined by urethral resistance. Critical stretch was produced whenever 2 oz. was added to the 6-oz. residue, and voiding thus occurred every two hours. Impending detrusor contraction was signaled by an urgent desire to urinate and could not be induced or inhibited by intent.

The identical type of automatic micturition was observed with tabes dorsalis, paraplegia, multiple sclerosis, and diabetic polyneuritis with hemiplegia. The only common factor was inactivation of pelvic muscles.

Obviously, a cord bladder is not always the result of a particular nerve lesion. Therapy is not confined to tidal drainage or resection of the vesical neck but must be guided by the special conditions of each case.

Role of Heredity in Glaucoma

ADOLPH POSNER, M.D., AND ABRAHAM SCHLOSSMAN, M.D.*

In about 1 of 7 cases, glaucoma is inherited and usually follows the particular familial pattern involved, such as congestive, chronic simple, or chronic simple with congestive attacks. A person with inherited glaucoma probably should not marry into a family with the same disease.

Potentially glaucomatous subjects may be detected by pupillography, which indicates the state of the autonomic system and particularly of the hypothalamic center. Close relatives of every patient with the disease should have pupillography and provocative tests so that latent or early disease may be detected.

Routine examinations by Adolph Posner, M.D., and Abraham Schlossman, M.D., of the Manhattan Eye, Ear and Throat Hospital, New York City, of 373 unselected patients with primary glaucoma revealed 51 instances of genetic disease, representing 30 families. In addition, 48 other members of the same families were known to be affected. These figures increase the number of reported pedigrees by one-third, since only 90 families with such heredity have been previously listed.

Hereditary glaucoma is often associated with constitutional disease in the family, especially vascular hypertension and diabetes or arteriosclerosis, toxic goiter, psychoneurosis, cataract, convergent strabismus, or obesity.

Some apparently sporadic cases may actually be genetic, or familial disease may occasionally remain dormant for a lifetime. At times the defect seems to skip a generation and return in the next.

* Role of inheritance in glaucoma. Arch. Ophth. 41:125-150, 1949.

Medical Forum

Discussion of articles published in MODERN MEDICINE *is always welcome. Address all communications to The Editors of* MODERN MEDICINE, *84 South 10th St., Minneapolis 3, Minn.*

Obtaining the Metabolic Rate*

TO THE EDITORS: I agree with Dr. C. I. Reed that in many laboratories basal metabolic reports have no reliable significance. They are carelessly done, and even the mathematics is in many instances erroneous.

I do feel, however, that with well-trained technicians and modern equipment the procedure is sufficiently correct to meet clinical needs for all practical purposes. It may not be sufficiently accurate to meet the needs of anyone working in the fields of clinical research. Almost no Ph.D. would accept procedures carried out by technicians unless he personally had trained the technicians.

WILLIAM B. PORTER, M.D.
Richmond, Va.

► TO THE EDITORS: It is true that the determination of basal metabolic rates is not as susceptible to objective control as other laboratory determinations. Some initial skill, experience, and proper training are necessary before proper metabolic rates can be determined.

My feeling is that clinicians waver between credulity and incredulity, instead of searching carefully for adequate orientation. The result is that one frequently hears suggestions to discard many types of laboratory tests. My own feeling is that we should strive to make the laboratory tests reliable. I do believe that many advances in medicine are dependent upon them.

By no means am I trying to suggest that basal metabolic rate determinations are even customarily done in a reliable manner. I would like to suggest that you examine "A Survey of the Accuracy of Chemical Analyses in Clinical Laboratories" (*Am. J. Clin. Path.* 17:853, 1947). You will notice that the simplest chemical determinations are also performed in a widely unreliable manner. In comparison to these, Dr. Reed's scatter of from 27 to 59 calories seems relatively good.

When I am ill, I will hope to have the services of a good technician as well as of a good physician.

G. T. EVANS, M.D.
Minneapolis

► TO THE EDITORS: Concerning the reliability of basal metabolism rates as ordinarily determined, I may say that I am entirely in accord with the opinion expressed by Dr. C. I. Reed.

WALTER L. PALMER, M.D.
Chicago

*MODERN MEDICINE, May 1, 1949, p. 52.

► TO THE EDITORS: In the hands of a qualified, personable technician who maintains strict attention to detail, the postabsorptive oxygen consumption can be determined with sufficient accuracy to establish the reliability of apparatus and methods in current use. This is frequently not the case among routine tests in which any particular estimation is more nearly an index of the ability of the technician than of the basal metabolic rate. Hence, the major disadvantage of current methods lies in their dependence upon the ability of those who employ them.

It follows, therefore, that unreliable metabolism determinations usually reflect inadequacies in personal performance of laboratory workers as well as of those who select, train, and supervise them. The metabolism technician must realize the absolute necessity for conscientious attention to detail and the physician provide critical yet helpful and constructive supervision. Other things being equal, the individual of pleasant and reassuring personality is to be sought for the task of performing determinations.

In our experience it is not uncommon for the physician to accept, perhaps with some equivocation, the calculated basal metabolic rate without pausing to inspect the tracing or to check the calculations. Often he fails to obtain the patient's reaction to the test; almost never does he observe an actual determination in an attempt to detect faults in a technic with which he is relatively unfamiliar.

It should be recalled that an isolated determination of the basal metabolic rate, particularly the patient's initial one, is apt to be unreliable and that any incongruous results should be verified by further tests. Also, it may be quite difficult if not impossible to obtain a satisfactory measurement in an occasional patient who cannot adapt himself to the procedure. A reassuring and considerate attitude on the part of the technician will do much to eliminate inconsistencies of this sort.

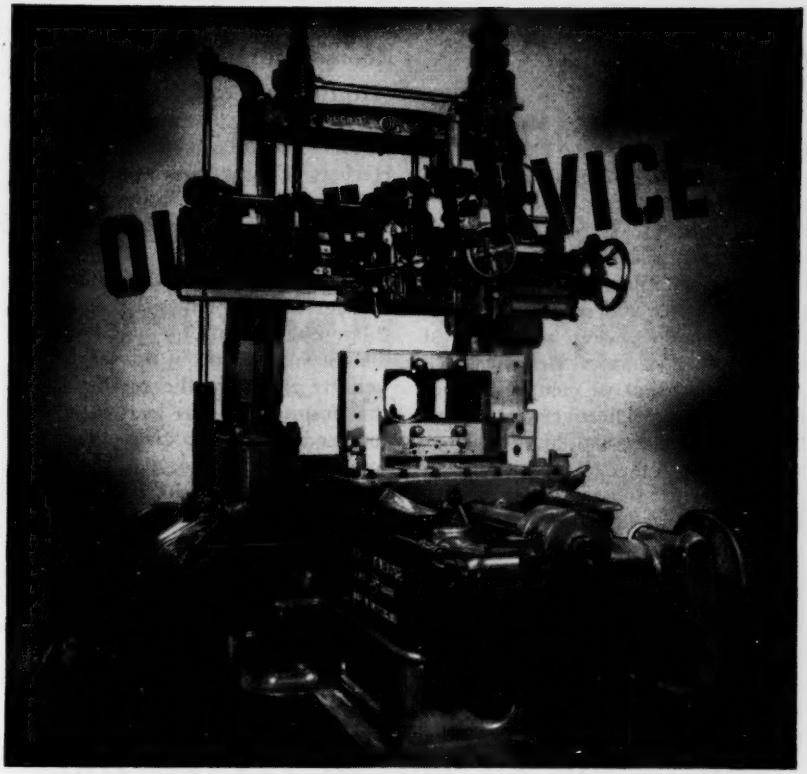
When one considers the profound effects of intense emotion upon numerous physiologic processes it is not surprising to find considerable day-to-day variation in the metabolic rates of those who are ill. Such effects are incompletely understood but are probably in part responsible for the fact that a truly basal state is a difficult one to achieve. The substitution of another term for "basal metabolic rate," however, has little to recommend it in ordinary usage.

BEVERLY T. TOWERY, M.D.
Nashville, Tenn.

► TO THE EDITORS: I believe that Dr. Reed is correct in stating that the procedure for determining metabolic rates as applied clinically is rather unreliable. However, in a purely clinical test of this nature, scientific accuracy is not essential.

My opinion is that if technicians are carefully trained and conscientious and have learned to evaluate the condition of the patient undergoing the test, it is a procedure which is of great help to the clinician. Like most other laboratory tests, it will always bear repeating and one should not reach final decisions of importance on the results of one test alone.

ALEX. M. BURGESS, M.D.
Providence, R. I.



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Refrigeration in Obstetric Crises*

TO THE EDITORS: I read with interest Dr. Frederick M. Allen's article on refrigeration in obstetric crises and your Medical Forum commentaries dealing with the subject. I am surprised that while the use of the abdominal tourniquet and manual compression of the abdominal aorta was discussed, no mention was made of the various mechanical devices which allow application of compression of the aorta more effectively, with less discomfort to the patient and without any effort for the physician.

The compressor models of Sehrt, Haselhorst, and Engelmann and even the simple compressorium of Rissmann are certainly superior to violent constriction of the whole abdominal cavity and to manual compression of the abdominal aorta, which cannot be maintained very long and ties down a hand that, in an emergency, is needed elsewhere.

I once saw the instantaneous and life-saving effect of this compressor method in a terrific atonic postpartum hemorrhage of a multipara who had given birth to her eighteenth baby. The rapid, complete, and final control of the dangerous situation, effected without any appreciable discomfort to the patient and requiring neither effort nor any great skill on the part of the obstetrician, was nothing short of dramatic.

Why resort to heroic measures if simpler and safer methods can be employed?

HENRY A. TROY, M.D.

Oceanside, N.Y.

*MODERN MEDICINE, Jan. 15, 1949, p. 68.

Rooming-in Plan*

TO THE EDITORS: Concerning the advantages of the rooming-in plan for mothers and infants described by Dr. Herbert Thoms and associates and Dr. Thaddeus L. Montgomery and associates, I wish to make the following comments:

It seems to me that the greatest advantage of this plan is that it teaches the mother to care for her infant under the supervision of trained personnel. By the time the mother leaves the hospital she has learned to care for her baby. It also gives the mother something to do so that she moves about more while she is in the hospital.

I feel that the plan has some objections. I am sure that many mothers would be disturbed by the baby's crying. I am quite sure that the plan would require more room in a hospital and that many maternity services could not be so arranged.

I am also not sure that better maternal and infant psychologic relationships are created. We have not seen fit to change the routine in our own hospital over to this plan.

J. H. RANDALL, M.D.

Iowa City, Iowa

► TO THE EDITORS: Here in Pasadena a rooming-in-plan is just being inaugurated at the Huntington Memorial Hospital. We are hoping that from personal contact with such a system we may learn something that would be of interest.

L. GRANT BALDWIN, M.D.

Pasadena, Calif.

* MODERN MEDICINE, Mar. 1, 1949, p. 61; Apr. 15, 1949, p. 66.

► TO THE EDITORS: Rooming-in is the term used in the obstetric department of the hospital when infant and mother are kept in the same room.

The advantages of such a plan would be that the mother's mind is at rest because of being with her baby. She can assure herself that the baby is healthy and has no deformities. Furthermore it gives the mother a chance to become better acquainted with her child and his immediate needs, so that when she takes her infant home she isn't afraid to handle the child and he is not a little stranger to her. While in the hospital the mother can gain a certain amount of confidence because if she has any trouble in caring for her baby a nurse is always at beck and call to help her.

Separation of infants from their mothers is unhealthy because it creates an early difficult parent-child relationship. Certain mothers become very nervous and develop phobias concerning their ability to handle the infant. Early ambulation also gives the mother a better opportunity for caring for her child.

The infant will have certain advantages in this plan. Primarily, he will be isolated from other infants and thereby protected from epidemics of impetigo and probably other infantile diseases. He will not be handled as much or transported through long halls between the nursery and the mother's room and will always be under the watchful eye of the mother.

There are definite disadvantages to this plan, one being that a larger nursery staff might be needed and another that some mothers will not want to take care of their babies at the hospital because they feel they need a certain amount of rest after delivery. Other mothers are not adapted to care for their infants immediately. In either case the issue should not be forced.

About twenty years ago rooming-in was practiced at the Dante Hospital in San Francisco with a glass cubicle for the newborn baby in every obstetric room. Mother and child got along very nicely. Due to economic conditions this plan was abandoned because practically all obstetric patients at Dante Hospital had special nurses.

In concluding, we feel that the advantages obtained by this plan overshadow the disadvantages. An attempt should be made to keep baby and mother together.

ABRAHAM BERNSTEIN, M.D.
HENRY C. BERNSTEIN, M.D.
San Francisco

Treatment for Multiple Sclerosis*

TO THE EDITORS: I should like to comment on one of the suggestions given in Dr. I. Mark Scheinker's instructive article on multiple sclerosis. This was the recommendation for the administration of adrenal cortex in the later phases of the disease.

At the possible risk of adding to some confusion that now exists between multiple sclerosis and amyotrophic lateral sclerosis, I must admit to no experience with the former, but can document the beneficial effect of adrenal cortex therapy on muscular function in the latter condition.

I have studied 4 cases of amyotrophic lateral sclerosis within the past two

* MODERN MEDICINE, Apr. 1, 1949, p. 75

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years, having initially become interested in their status at the behest of a science instructor in the New York school system, himself a subject and an astute observer of certain ignored features of the condition. He maintains constant contact with other subjects in this vicinity as well as with interested scientific agencies and has rendered many valuable contributions to general science. His suggestion of the possible use of adrenal cortex therapy was based upon his own observation of the accelerated progression of the disease, both in himself and in others, during periods of physical or emotional stress. He believed that one might utilize the known "anti-stress" fortification upon which the present method of assay of corticosteroids in laboratory animals is based.

Through the kindness of the Products Research Department of the Parke-Davis Company, protracted parenteral adrenal cortex therapy has been made feasible for 4 patients. Two of these have shown an equivocal response, if any.

The other 2 patients have shown definite response of a dual nature, both salubrious. The immediate response is the cessation of fasiculations and increased muscular power upon a single administration of from 3 to 5 cc. of aqueous adrenal cortex extract, the daily dose. On continued administration, there appears to be a deceleration or even an arrest in the disease.

The latter response, overt in my cases only after several months of sustained therapy, will naturally be difficult of confirmation or refutation other than on a statistical basis, and data for this purpose might be unprocurable by any single observer because of the relative rarity of the condition. Pending the possibility of a later, definitive report, I feel that a citation of an experience similar to that implied in Dr. Scheinker's paper, in a condition with some similarities of symptomatology, may be justified.

ROBERT D. BARNARD, M.D.

Brooklyn

Management of Food Allergy*

TO THE EDITORS: The methods suggested by Dr. Theron G. Randolph for the management of food allergy are sound and can be used to advantage in institutions or offices dealing with allergic problems. However, they are rather complicated for the general practitioner.

The misconceptions mentioned cannot be stressed enough, especially the very doubtful value of the skin test, which should be abandoned. But there is another misconception which the author mentions only superficially, i.e., that precipitating factors, such as infections, menses, and states of tension, may not only obscure the results of the tests but may also be etiologically responsible for different conditions which the allergists claim to be of allergic origin. Even the leukocytic index is sometimes quite misleading.

Until we have a clearly defined objective basis for diagnosis of food allergy, this subject will always be controversial. The best that can be done now is to use the methods critically and, in borderline cases, watch for factors other than food allergy.

G. SCHILDER, M.D.

Vancouver, B.C.

*MODERN MEDICINE, July 1, 1948, p. 33.

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Diagnostix

Here are diagnostic challenges presented as they confront the consultant from the first clue to the pathologic report. Diagnosis from the Clue requires unusual acumen and luck; from Part II, perspicacity; from Part III, discernment.

Case MM-147

THE CLUE

ATTENDING M.D: I would like you to see a forty-two-year-old patient whose chief complaint is difficulty with vision. Her vision blurs and she is blind for as long as two minutes. She also has some ringing in her ears and vague headaches.

VISITING M.D: What is the nature of the tinnitus and headaches?

ATTENDING M.D: The headaches are intermittent, do not seem to be localized in any particular part of the head, and do not awaken her at night, but are aggravated by coughing, sneezing, or stooping. The attacks are apparently getting worse and may last for an hour or two. Aspirin or aspirin and codeine seem to give relief. The tinnitus began two years ago as a cricket noise in the left ear. She is now deaf in that ear and has an ataxic gait.

VISITING M.D: The corneal reflexes?

ATTENDING M.D: The left corneal reflex is absent.

VISITING M.D: The optic fundi?

ATTENDING M.D: She has bilateral four diopter choke.

PART II

VISITING M.D: I believe that the patient has an intracranial expanding tumor. The question is where is it and what is the nature of the lesion. Please give more details.

ATTENDING M.D: According to the patient, the earliest symptom was a sensation of blurred vision and a feeling that the left eye was bulging, although no one has observed protrusion. She had occasional spells of weakness five years ago when her knees seemed to buckle and occasionally she had headaches and saw flashing lights. These attacks were diagnosed as migraine by her family physician and were treated as such until two years ago when she began to have an ataxic gait. She noticed that she often lurched and bumped into objects, especially in the dark. This symptom progressed.

VISITING M.D: You mention the difficulty in walking at night. Are the proprioceptor sensations normal?

ATTENDING M.D: Yes. Deep tendon position sense and vibration are not disturbed. The pupils react to light and accommodation.

VISITING M.D: *(Examining the patient)* She is totally deaf in the left ear. There is a bilateral coarse nystagmus on looking to the right. Reflexes are hyperactive in the arms and legs and there are bilateral Babinski phenomena. Abdominal reflexes are absent. Cerebellar signs

are greater on the left than on the right. The finger to nose and heel to knee coordination are definitely impaired on the left side and she has adiadokocinesis. I note some weakness of the left side of the face and diminution in sensation over the fifth nerve area. Has an EEG been made?

ATTENDING M.D: Yes. There is a left occipital delta, grade 2.

PART III

VISITING M.D: *(Examining the head roentgenogram)* There is erosion of the sella due to increased intracranial pressure, but no evidence of tumor or of shift of the pineal body. Please give me the pertinent laboratory work.

ATTENDING M.D: Routine blood tests, urinalysis, and films of the chest are all normal.

VISITING M.D: Can I presume that the physical examination was normal?

ATTENDING M.D: Yes. General medical examination was not remarkable.

VISITING M.D: It would appear to me that the patient has an intracranial lesion, probably a tumor in the left cerebellar pontine angle. I would not advise a spinal tap because of the high degree of choke and the possibility of herniation of the cerebellar pedicles and the medulla into the foramen magnum. One must always be careful in advising spinal tap with a brain tumor. A neurosurgeon should be present, prepared to perform a decompression or operate for the tumor immediately.

ATTENDING M.D: What do you think is the nature of the tumor?

VISITING M.D: An acoustic neuroma.

ATTENDING M.D: Why do you say that?

VISITING M.D: Well, I always think in terms of the one or two striking clues which would lead to a diagnosis. As Oliver Wendell Holmes once said, "The characteristic thing about a polliwog is its wiggle." The characteristic thing about a cerebellar pontine angle tumor arising in the eighth nerve, such as an acoustic neuroma, is the beginning tinnitus in that ear followed by deafness. It is surprising how often this lesion is not diagnosed in the early stages. Then, thinking again about that polliwog, I go on to the history and examination and find little lights flashing in the differential diagnostic sphere. Several things are indicative here. All the symptoms can be attributed to a lesion in the base of the brain—cerebellar signs due to compression of the cerebellum on the side of the lesion and the cranial findings of involvement of the fifth and seventh nerve, and probably the ninth in this patient since there is some pharyngeal weakness. All these suggest a brain stem lesion. The sequence implies that it began in the eighth nerve. The neurosurgeon will probably do a suboccipital craniotomy.

PART IV

NEUROSURGEON: *(At surgery)* Here in the left cerebellar pontine angle is a large tumor. Frozen section biopsies show it to be an acoustic neuroma. The tumor is so large that it cannot be removed completely.

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Washington Letter

New Information on AEC Medical Program

One reason for the joint congressional committee's investigation of the Atomic Energy Commission was a sincere desire by some members of the committee to learn more about what the commission was doing. But there were other factors: the long-range struggle for the control of cheap power, partisan politics, personal animosities, and some ambitions on the part of the military.

AEC Chairman David Lilienthal, and indirectly the Division of Biology and Medicine, came under attack from some members of the committee on two points. Some committee members thought scholarships were granted without adequate security precautions. On this, Mr. Lilienthal finally agreed. The critics also charged that under the covering of a medical research program, radioactive isotopes were sent abroad for possible military use by other nations. On this, Mr. Lilienthal and other commission officials put up a vigorous defense, and the argument probably never will be settled.

While the investigation was going on, a few of the AEC's medical experts were busy preparing their sixth semiannual report to Congress. Medicine is one field of atomic development that will certainly produce immense, permanent, physical benefits—politics or no politics. The report is strictly nonpartisan, impersonal, and noncontroversial.

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"A.P.L." has been used successfully in the treatment of chronic cystic mastitis, threatened abortion, functional uterine bleeding, cryptorchidism, hypogenitalism, and Fröhlich's syndrome.

[1] Brown, W. E. & Bradbury, J.T.: Am. J. Obst. & Gynec. 53:749 (May) 1947

*"Secule"—Ayerst name to designate a special vial containing an injectable preparation in dried form.

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may be obtained from Government Printing Office and should be well worth writing for.

The following facts will be brought out:

► Starting from zero two years ago, the atomic medical research program has branched out until now some type of project is being financed at almost every important medical school and laboratory in the country. By count there are seventy AEC research contracts at sixty-five institutions. Four regional training centers have been established at the universities of North Carolina, Texas, Colorado, and Oregon.

► The AEC is financing a cancer research program and is publishing a bimonthly report of abstracts on atomic energy's relation to biology, medicine, and biophysics. This report reaches every important medical library.

► There is notable progress in applying radioactive isotopes to research in diagnosis and treatment of diseases.

► A great deal has been learned about how to lessen radiation injuries by treatment prior to exposure, and researchers are making slow but definite progress in developing postexposure treatments.

Specific Treatment for Radiation Exposure

The report to Congress will make plain that no single highly effective method for treating severe radiation burns has been developed and that there is no assurance such a treatment will ever be found. Dr. John Z. Bowers, deputy director of the Division of Biology and Medicine, told MODERN MEDICINE that a combination of treatments seems advisable, including multiple transfusions and use of the antibiotics, antiheparin agents such as protamine and toluidine to stop hemorrhages, antihistaminic drugs to control nausea and shock, and provision for adequate nutrition intravenously.

Work Progresses on Preexposure Treatment

The AEC's report to Congress will show specific, important progress in learning how radiation injuries can be minimized by advance treatment. Research projects in this field are under way at a number of institutions, including University of Rochester, Oak Ridge, University of California, University of Oregon, University of California at Los Angeles, and Argonne Laboratory. These experiments have shown that radiation fatalities among mice can be definitely reduced by use, before exposure, of female sex hormones, certain amino acids, and adrenal cortical hormones.

Cobalt as Possible Substitute for Radium

In the area of general medical diagnosis and treatment, AEC's researchers have heartening progress to report. Radioactive cobalt, for instance, may offer a desirable replacement for radium in the treatment of cancer. Progress is being made and the investigators hope eventually to make such a recommendation.

Two of the most promising other isotopes are radioactive iodine for diagnosis of the thyroid diseases and treatment of thyroid cancer and hyperthyroid conditions and radioactive phosphorus for the treatment of chronic myeloid leukemia and polycythemia vera.

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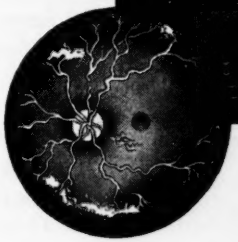
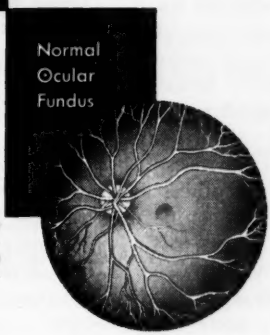


Normal Ocular Fundus



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Public Health Gets Attention

With the big argument on a national health program postponed for another year, congressional committees are finding time to look into some specific shortages in the medical services.

Brig. Gen. James S. Simmons, dean of Harvard's School of Public Health, testified that several public health schools have had to close, and that others are about to close. "Practically all need additional funds to stabilize current operations," he said.

Gen. Simmons advocated both immediate and long-range programs of assistance. He said scholarships are needed for graduate students if the schools are to be kept open.

The General and several other witnesses emphasized that it was senseless to talk about expanding the country's medical services when the demand cannot be met for personnel to staff the services.

Help to Schools Urged

Witnesses were in general agreement that immediate and direct financial assistance to the institutions themselves was the most urgent requirement. Disagreement arose, however, about the extent of scholarships; some spokesmen said that scholarships should cover all student expenses, including food and lodging; others argued that available funds could be stretched by restricting grants to tuition, books, and equipment.

The long-established systems of loan funds for students came under criticism from Carlyle F. Jacobson, a spokesman for the American medical colleges. He said that federal scholarships were the only solution, because a young man starting his career with a debt of $5,000 to $10,000 was facing almost impossible hardships.

The committee was told that a minimum of $100,000,000 is needed for medical, dental, and nursing education.

U.S. Chamber Active Against Truman Plan

The U.S. Chamber of Commerce has stepped up its campaign against the Truman health insurance plan with a new pamphlet, *You and Socialized Medicine, the Basic Facts and a Call to Action,* an appeal for action and education at the local level.

On the other side, the Committee for the Nation's Health has started publication of *Health Insurance News,* designed to win support for the Truman plan.

In contrast, the hearings on the Truman plan are stirring up little interest in Washington. The legislation is dead for this session, and many of the witnesses have been heard several times before.

Armed Forces Campaigning for Physicians

The Air Force publicity staff is working to build up its newly created independent medical service. To overcome the major objections of doctors to a career in the Armed Services, Gen. Hoyt Vandenberg promises that the Air Force will do everything in its power to give medical men stability in a career, the best of housing, and advanced training and that doctors will be relieved of unnecessary nonprofessional work. . . . The National Guard is offering special commissions to 1949 graduates of approved medical schools.

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Short Reports

PSYCHIATRY

Curarization with Electroshock Therapy for Mental Illness

Traumatic complications of electroconvulsion treatment of psychiatric patients are avoided if therapy is modified by curarization. For this purpose Drs. J. A. Hobson and F. Prescott of London prefer decamethonium iodide to *d*-tubocurarine. The major drawbacks of electroconvulsion therapy such as fractures, dislocations, and cardiovascular accidents are eliminated as effectively by one agent as the other. Decamethonium iodide, however, has no tendency to produce histamine-like reactions, and curarization passes off more rapidly. Some 200 treatments have been given 40 patients without occurrence of complications, although the persons treated included individuals to whom electroconvulsion treatment without preliminary curarization should have been dangerous. No patient should be given curare unless efficient facilities for controlled respiration are present and the administrator is competent to deal with the apneic patient. Injection of stimulants or analeptics cannot replace the provision of a clear airway and rhythmic insufflation of oxygen.

Lancet 254:817-820, 1949.

"Never mind, it isn't important. It's just that the doctor said I'm going to have another baby."

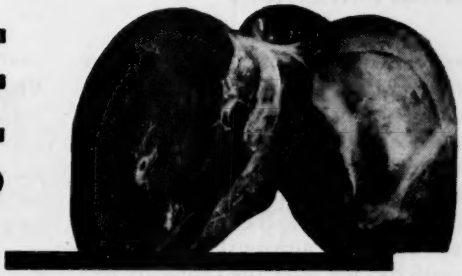
ANTIBIOTICS

Aureomycin for Arthritis

Polyarthritis caused in rats by inoculation with pleuropneumonia-like organisms may be prevented or cured by aureomycin, which apparently is as efficacious an antiarthritic agent as gold salts. At the International Congress on Rheumatic Diseases held in New York City, Dr. William C. Kuzell of Stanford University, San Francisco, and associates

CHOLINE

(FLINT)



for a

Better Prognosis in Chronic Hepatitis

The establishment of an etiologic relationship between fatty infiltration of the liver and the development of hepatic cirrhosis has stimulated an extension of interest into the role of fatty liver in diseases in which extra-hepatic clinical features have formerly claimed major attention.

The intensely fatty liver of the infantile pellagrin revealed at autopsy has now assumed a position of greater interest in the light of serial biopsy studies at various stages of this disease. These data reveal that fatty infiltration of the liver is a constant feature of the syndrome of pellagra, and that an accumulation of fat in the liver develops early in the course of the period of malnutrition.*

It appears, moreover, that the degree of fatty changes in the liver is a better index of the prognosis of pellagra than the healing of external lesions in that hepatic pathology may remain silently active despite symptomatic improvement.

Serial liver biopsy studies in pellagra reveal that failure to arrest or to reverse fatty infiltration of the liver in the early, acute stages of malnutrition may result in permanent alteration of hepatic structure. Neglect of therapy culminates in the development of pigmentary cirrhosis, thus indicating that hemochromatosis is a disorder resulting from a chronic dietary imbalance. Such evidences of a direct relationship of fatty degeneration of the liver to the prognosis of pellagra emphasizes the growing importance of lipotropic factor choline as an adjunctive therapeutic agent.

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*Gillman, J. and Gillman, T.: Structure of the Liver in Pellagra, Arch. Pathol., **40**:239-263 (Oct.) 1945.

recounted results of antibiotic treatment of inoculated rats and mice. Aureomycin prevented development of arthritis. When arthritis was permitted to develop, aureomycin effected a cure within forty-eight hours. Streptomycin was beneficial but not as effective as aureomycin. Chloromycetin did not alter the course of arthritis. Neither did citrinin. Penicillin made the infection in rats worse.

PEDIATRICS

Aureomycin Is Helpful in Treating Pertussis

Duration and intensity of whooping cough are diminished by oral dosage with aureomycin hydrochloride. Results are most favorable when the antibiotic therapy is started early in the course of the disease, state Dr. Joseph A. Bell and associates of the National Institutes of Health, Bethesda, Md. Trials of the drug were made among children in Norfolk, Va. Comparisons were made of 20 children given the drug and 380 not treated. Paroxysms were promptly reduced in the treated cases; early subsidence of night coughing and vomiting was notable. By a schedule designed for home use, 0.5 gm. of aureomycin per kilogram of body weight was given in divided doses over an eight-day period. Usually one or two 250-mg. capsules were mixed in a cup with a teaspoonful of sweet cherry syrup. If vomiting occurred immediately, the dose was repeated. Preliminary trials had demonstrated that subcutaneous aureomycin delayed or prevented death in mice infected intracerebrally with *Hemophilus pertussis.*

Pub. Health Rep. 64:589-598, 1949.

TREATMENT

Vitamin B_{12} Orally

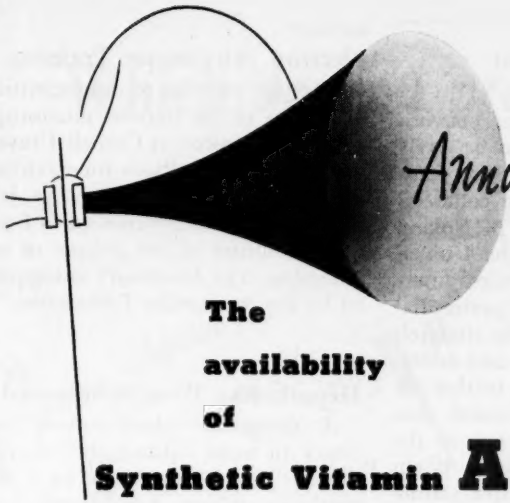
Isolation of pure vitamin B_{12} makes the substance available for general use. Parenteral administration is still indicated for anemic patients with severe cardiac failure, neurologic changes, or gastrointestinal disturbances. For others, however, oral administration may be used. Dr. Tom D. Spies of Hillman Hospital, Birmingham, Ala., and associates of Calixto Gracia Hospital, Havana, Cuba, find that oral administration of large doses of vitamin B_{12} to persons with pernicious anemia, nutritional macrocytic anemia, and tropical sprue in relapse produces a positive hemopoietic response and general improvement. Reticulocytosis reaches a peak around the seventh day. Subsequent red blood cells and hemoglobin content increase. Response varies with the individual, but patients can take from thirty to fifty times as much material by mouth as by injection. If acute combined system disease develops, therapy can be continued and satisfactory response obtained if the material is incubated with human gastric juice. Oral administration of the incubated mixture cuts down the amount of material that can be ingested to about five to ten times the parenteral dose.

South. M. J. 42:528-531, 1949.

EDUCATION

Psychiatric Guidance

Yale University and Vassar College have each received $2,000,000 from the Old Dominion Foundation headed by Paul Mellon, Washington, D.C., for psychiatric studies.



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EXPERIMENTAL SURGERY

Production of Collateral Coronary Circulation

Vascular communications between the heart and the lung can be established by cardiopneumonopexy. Seeking a means of producing collateral coronary circulation, Dr. B. Noland Carter and associates of the University of Cincinnati introduced finely powdered asbestos into the pericardial sacs of 19 dogs. New vascular channels between the myocardium and adherent lung were formed, but neither the amount or direction of blood flow nor the duration of patency of the channels could be determined. When India ink was injected after cardiopneumonopexy, the filling of vessels, both superficial and deep, was greater in the cases made ischemic by ligation of the anterior descending branch of the left coronary artery than in normal hearts. Infarcts were less extensive and mortality was lower when cardiopneumonopexy was done before ligation.

Surgery 25:489-509, 1949.

ONCOLOGY

Cancer of Virus Origin

Malignant mouse tumors may be propagated from dried tumor tissue, indicating that the growth is of a continuing, that is, viral nature. Success in transmission of sarcoma from dried mouse tissue leads Dr. W. E. Gye of the Imperial Cancer Research Fund, England, to believe that the cause of cancer in mammals is similar to that in birds. Propagation of the cancer was greatly facilitated if the tumor tissue was frozen for some time before drying.

Brit. M. J. 4603:511-513, 1949.

EDUCATION

Electron Microscope Training

A formal program to train scientists in the use of the electron microscope is being organized at Cornell University, Ithaca, N.Y. Plans for establishment of an electron microscopy laboratory have been announced by Dean S. C. Hollister of the college of engineering. The laboratory is supported by the Rockefeller Foundation.

ANTICOAGULANTS

Heparin-like Drug Synthesized

A dangerous blood-clotting tendency in some cardiac and vascular diseases may be overcome by a new synthetic, sulfate mannuronic acid, called paritol. Chemically similar to the more expensive heparin, paritol acts quickly but has a more prolonged effect than the naturally occurring substance. The material was used successfully with 11 patients, announced Dr. Joseph Seifter of Philadelphia and associates at a recent session of the New York Academy of Medicine. Undesirable reactions sometimes occur but either clear up spontaneously or respond to treatment with epinephrine. No signs of permanent damage have been detected. The drug is not yet ready for general use.

LICENTIATURE

3,300 More Physicians

During 1948, according to the American Medical Association Council on Medical Education, 6,597 doctors entered the ranks of the medical profession. Deaths among doctors numbered 3,230 for last year, leaving a net increase of 3,367 in the physician population of the United States.

How Is the British Doctor Getting Along?

(Continued from page 45)

Britain's Socialist Medical Association flatly seeks adoption of salaries and abolishment of private hospital beds. Not all socialist doctors agree.

Dr. Stephen Taylor, important Labor M.P., said that he once backed salaries but has changed his mind. "Only bad doctors favor them," he said. "You'd soon get some who did no work at all. Either they'd refuse to see patients or patients would refuse to see them. The great advantage of the capitation fee is that it leaves rewarding or punishing a doctor in the patient's hands."

Dr. Taylor saw "no likelihood of a salaried service." But a respected medical editor, after listing his objections, including need of "disciplinary machinery to get slackers to work and the beginnings therefore of autocracy," forecast that such a service was "about ten years away."

Pro-salary socialists count on gradual acceptance of the government as employer and on a new generation of doctors "conditioned to teamwork in public service."

How about bureaucracy? Many doctors complain this is the hardest pill they must swallow. Leading Laborites themselves say Britain's socialism "stands or falls by the freedom it gives to ordinary men and women."

Britain's health minister directly controls hospitals, specialists, bacteriology laboratories, and a blood bank network. Hospitals are supervised by regional boards. Under these are local management committees for day-to-day administration. On the whole the same people run the hospitals who did before. But only teaching hospitals have kept their old boards.

Local executive councils direct the GP service. Each council has 25 members, all volunteers, much like U.S. draft board members. Little is run directly from London. Final authority, however, usually remains with the health minister.

For advice, Bevan has a 41-member central health service council. Six members represent medical associations. Bevan names the rest from many fields.

The health ministry has a paid health plan staff of only 800, including typists. The service is run mainly by the 10,000-odd volunteers. Local executive councils, however, have about 40 administrative and clerical workers each, a total of some 5,500.

The individual doctor treats patients as he wishes, and there have been few complaints.

A doctor must get permission from the local executive council to enter practice. Critics cite cases in which partnerships have been refused permission to choose a new partner.

The first body to recommend dismissal of any doctor is the local executive committee, which includes at least 7 doctors. A tribunal can reverse this decision. A doctor can make final appeal to the health minister.

The BMA has unsuccessfully demanded that the dismissed doctor be able to appeal to a court of law, too.

He can do so now only on points of law, but not on facts of dismissal.

It still seems too early to assess bureaucracy's final role. On July 3, 1949, two days before the service began, the *British Medical Journal* commented that the plan "will have to evolve over many years, and there will be much trial and error before anything like a perfect service comes into being."

Dr. Hugh Clegg, the *Journal's* capable editor, told me he now believes "prospects are really good that we can make this a first-class health service." He added: "The big dangers are too much paper work, and the role of the bureaucrat. I think we will eventually work things out if we can hold the administrators in check, and that's going to be difficult."

Health Minister Bevan himself said in February: "What we are trying to do is to work out a system of resilient administration with as little bureaucracy as possible, with as much local self-government as possible, and yet at the same time protect the public purse against extravagant administration."

"I'm batting zero. Every time I find one thing I lose another."

But he added that the government needed "at least one year's experience."

Most doctors still back the BMA, though many are bitter at what they call its "surrender" a year ago to Bevan.

The BMA this spring organized the new British Medical Guild—an identical twin, with the same trustees and same members—to slug where the BMA cannot legally negotiate. Guild funds, collected from voluntary contributions, will be used as "a financial weapon in disputes," actually much like a strike fund for doctors who lose income by taking action the guild may advise.

"Mass resignation of doctors," sometimes talked of, is not likely. But it would please the 2,500-member Fellowship for Freedom in Medicine, organized last winter by aging Lord Horder, former physician to King George VI. Fellowship leaders expect nothing from Labor but hope for Conservative victory in the next election.

One of Lord Horder's lieutenants, Dr. E. C. Warner, outlined Fellowship goals to me:

1] Give drugs and grants to private hospital patients.

2] Permit Britons who prefer private care to "contract out" of the health plan, neither contributing nor benefiting.

3] Lessen administration by laymen.

4] Curtail certificate-signing by doctors.

5] Repeal the part of the health act prohibiting doctors from buying and selling practices.

6] "If possible," wistfully said Dr.

Warner, "wipe the health act off the books" and go back to Britain's old workman's health insurance, but include dependents and "make free medicine available to the poor."

Little of this program will ever get a hearing. Even Ian Macleod, Conservative party home affairs chief, called much of it "unrealistic."

Macleod told me that the Conservatives would improve priority service for those who need it most, improve administration and reduce spending, and provide free drugs and medicines for private patients.

He said that the Conservatives might give private hospital patients a grant toward bed cost, charge for some appliances now furnished free, and give doctors the increased pay for the first 1,000 patients that the BMA is now asking.

If they oust Labor, the Conservatives will certainly slow the trend toward a salaried service. But they would do nothing radical to socialized medicine. And a "doctors' rebellion," supported by neither Labor nor Tories, would quickly collapse.

Socialized medicine in Britain plainly needs many improvements to check the real danger that the quality

of family doctors will deteriorate permanently through overwork. Talk to a few of the program's best informed friends, and they will tell you the steps they must take. Yet impoverished Britain has neither the money, manpower, nor resources to take them.

Britain needs:

► *More doctors.* Young men and women willing to apply are not lacking, but medical schools are pushed to the limit. New schools would require buildings, equipment, and staff that do not exist.

► *Other health workers.* Nurses, trained midwives, dentists, and technicians are scarce. At least 45,000 nurses are needed to staff existing and proposed hospitals. Hospital waiting lists frequently stretch ahead for months, even years, often with disastrous results.

► *Health services.* Facilities are essential to ease doctors' loads. For instance, follow-up programs are needed for chronic patients, such as those with diabetes or asthma.

► *Broad public health services.* Tuberculin testing of cattle and pasteurization of all milk, for example, would cut Britain's heavy toll from tuberculosis.

► *Modern health centers.* Most authorities agree that such centers are the paramount need. It is estimated that they could save 25% of each doctor's time and free him for better medicine, study, and rest. The theory is that a nation with limited facilities has enacted unlimited medical service

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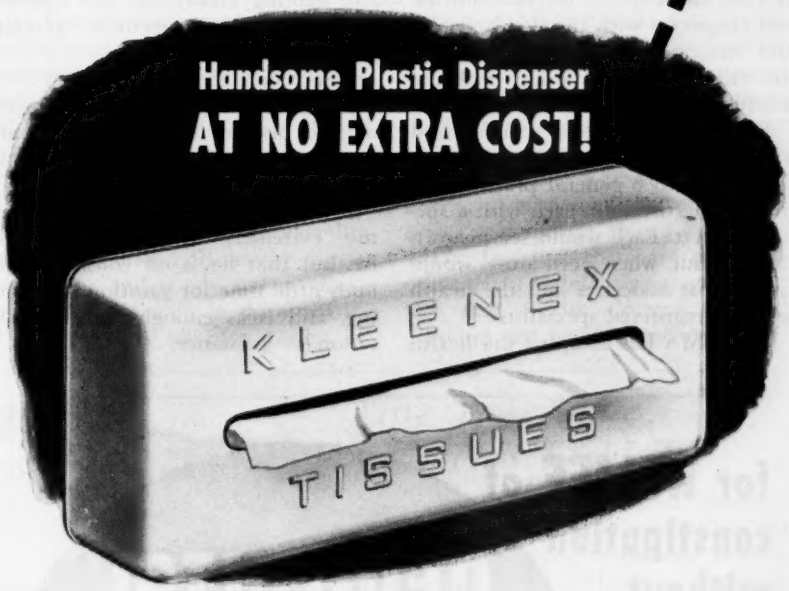

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and therefore must utilize every resource with maximum efficiency.

Britain's original health service plans called for great numbers of centers. The plans were that doctors would have offices there, share nursing and clerical help, use the laboratories, and cooperate with the dentist, child and maternal health workers, and the visiting nurses. Group medicine would increase.

British thinking today tends toward a modification of the group practice idea—say 5 to 8 general practitioners in legal partnership, each with a special interest. Each would see his own families but, when need arose, would call on his associates and the health service's registered specialists.

The BMA has accepted the health center idea "on an experimental basis."

An official BMA report recognizes that general practitioners have a "unique advantage" inasmuch as they are constantly visiting patients' homes, and gaining knowledge and contact without which treatment is "gravely handicapped."

The report then:

1] Opposes complete abandonment of solo practice but concludes that, in cities at least, disadvantages outweigh advantages.

2] Says that solo practice attracts the "extremely valuable" individualist, but that he is on constant call, finds little time for vacation or training, and lacks enough daily consultation or assistance.

3] Decries "waste of professional time" by isolated doctors and calls for as much nonmedical help as possible.

4] Attacks the artificial line between private and public health services.

5] Finally, recommends voluntary health center groups—continuing the "personal doctor-patient relationship" and developing "the family as a clinical unit" and the general practitioner as "coordinating figure."

In Britain today, health centers, hospitals, medical schools, laboratories, and other facilities to ease Britain's medical load all require capital investment and goods and services—just as do steel mills or shipyards.

To get Marshall plan funds, attempt to keep her economy stable, and achieve an economic recovery which is still far away, Britain is committed to spending as little as possible on government services.

Only one health center is now under construction, and few more are scheduled. Many doctors are pleading that health centers be organized in old houses or prefabs, if necessary.

Dr. Harry Boyde, London, wrote the *British Medical Journal:* "in these could be learned the art of cementing persons into a team—much more important even than that of bonding bricks and mortar into a building."

The fact that there are no bricks or mortar is plainly discouraging. The fact that British doctors are still thinking and planning offers hope.

Current Books & Pamphlets

This catalogue is compiled from all available sources, American and foreign, to insure a complete listing of the month's releases.

Medicine

DIABETES AND ITS TREATMENT *by* Joseph H. Barach. 326 pp., ill. Oxford University Press, New York City. $10

DIE BIOLOGISCHE INFEKTIONSABWEHR DES MENSCHLICHEN KÖRPERS *by* R. Bieling. 2d ed. 216 pp. Franz Deuticke, Vienna. 13 M.

MEDICINE: VOLUME II, DIAGNOSIS, PREVENTION AND TREATMENT *by* A. E. Clark-Kennedy. 522 pp. E. & S. Livingstone, Edinburgh. 25*s*.

PRACTICAL ASPECTS OF THYROID DISEASE *by* George Crile, Jr. 355 pp., ill. W. B. Saunders Co., Philadelphia. $6

LEHRBUCH DER SPEZIELLEN PROGNOSTIK INNERER KRANKHEITEN *by* H. Curschmann. 3d ed. 304 pp. Ferdinand Enke, Stuttgart. 16.50 M.

FOOD POISONING *by* Gail Monroe Dack. 184 pp. University of Chicago Press, Chicago. $3.75

Otology

ZINC IONS IN EAR, NOSE, AND THROAT WORK *by* A. R. Friel. 50 pp., ill. John Wright & Sons, Bristol. 5*s*. 6*d*.

PHYLOGENESIS OF THE EAR *by* Louis Guggenheim. 277 pp., ill. Murray & Gee., Inc., Culver City, Calif. $12.50

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The real pioneering task was to develop better products leading to more reliable and scientific contraceptive methods. Year after year Lanteen moved resolutely toward this goal, and, through continuous research and study, the Lanteen Diaphragm and Jelly method was developed.

With the years came gradual recognition. Many of those opposed to contraception came to see the rightness of the cause Lanteen had so steadfastly supported. The improved Lanteen Method was hailed as the answer to a difficult problem. Now, after two decades of pioneering, Lanteen is still a leader in this field. The Lanteen Diaphragm and Lanteen Jelly are widely prescribed as a most modern, scientific advance in contraceptive technique.

These twenty years have indeed been years of achievement.

Lanteen Jelly contains: Ricinoleic Acid, 0.50%; Hexylresorcinol, 0.10%; Chlorothymol, 0.0077%, Sodium Benzoate and Glycerine in a Tragacanth base.

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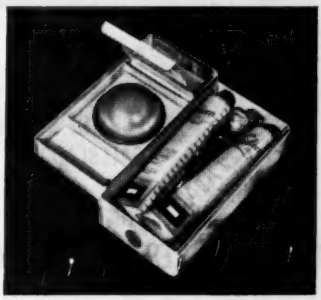


PATIENTS . . . I Have Met

The editors will pay $1 for each story published. No contribution will be returned. Send your experiences to the Patients I Have Met Editor, MODERN MEDICINE, 84 South Tenth St., Minneapolis 3, Minn.

Seeing Is Believing

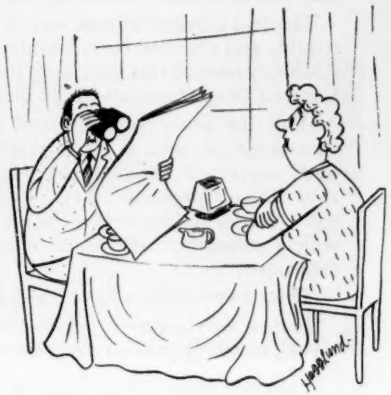
After reviving the patient, the doctor asked, "How did you happen to take that poison? Didn't you see the word 'poison' on the label?"

"Yeah, I saw it but I didn't believe it."

"Why not?"

"Because right underneath the word 'poison' was another word in bigger letters that said 'lye'."—B.W.

Tommy, aged five, and the oldest of a family of five, awakened from a tonsil operation to ask "Where's my baby?"
—J.A.G.



"John, I still say that you need glasses."

Spot Diagnosis

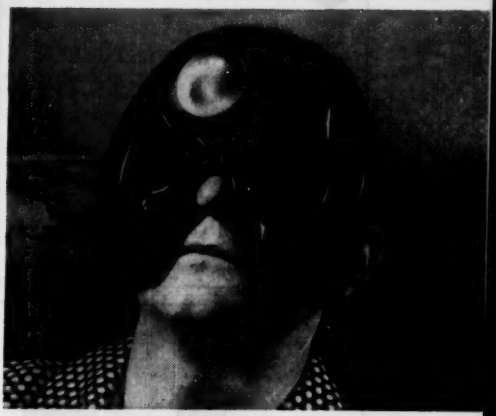
Two junior medical students had just left a lecture on physical diagnosis when they spied a man ahead of them waddling along in a peculiar gait.

"Bet a buck he's got hemorrhoids," challenged one.

"I'll take you," assented the other, "because he really has gonorrhea."

To settle the wager they went up to the man, explained the bet, and asked his confirmation.

"You're both wrong," said the waddler. "But cheer up, I was wrong too. I thought it was just gas."—S.E.D.



Curved to fit better, larger to cover more area

THESE three photographs show how ideally the new Anode latex hospital products are designed to treat specific areas with greater effectiveness.

The water bottle has a corrugated surface so that it can be wrapped around the arm or leg, curved to fit the contour of the body. Horizontal ribs distribute the water evenly inside the bottle. The tying anchors keep the bottle in place. Because the bottle is larger, a greater area can be covered.

The ice helmet is molded to fit, can be held on the head when the patient is erect or reclining. The face or sinus mask is shaped, closely fitting the face as no other bag can.

What these photographs don't show is the superior construction. All are made of highest grade latex. Walls are of uniform thickness, glass-smooth surfaces are soft and pleasant to the touch—easy to clean—there are no seams to split or burst, no pits, no imbedded dust or foreign particles. These hospital products are *guaranteed for five years* against defects in materials and workmanship. Sold by surgical dealers, hospital supply houses and drug stores.

Ask your druggist or dealer for

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RUBBER PRODUCTS FOR HOME AND HOSPITAL

Had a Hunch

A girl from south of the border was giving the doctor a little difficulty. Although he spoke excellent Spanish he was having a time eliciting a history. Preliminary examination suggested pregnancy. The girl was unmarried and he was unable to make her understand that she might be pregnant. Finally he asked her if she was a virgin. She said she didn't know, whereupon the doctor completed the examination.

Queried the senorita, "Am I a virgin?"

"It seems you are not," replied the doctor.

"I was afraid of that," she exclaimed.—A.M.H.

"The greatest cause of sleepwalking," cracked the intern, "is twin beds."—M.C.

Overheard in the Waiting Room

►First little Miss: "My mother is expecting a baby. What is your mother expecting?"

Second little Miss: "My mother is expecting the doctor to remove her garter."
—M.K.B.

►Mrs. A: "What kind of an operation did you have?"

Mrs. B: "I guess he took out just about everything along with the baby crib, but he did leave the play pen."—M.R.R.

"A little wider, please."

so safe...

The more than two billion TAMPAX tampons purchased in the past twelve years (plus extensive clinical tests*) bespeak the inherent safety of these dainty intravaginal cotton guards.

They do not cause vaginitis or erosion, and cannot block the flow. The three absorbencies (Regular, Super, Junior) individualize menstrual hygiene—and are amazingly comfortable and convenient, and thoroughly adequate.

*West. J. Surg., Obstet. & Gynec., 51:150, 1943; J.A.M.A. 128:490, 1945; Am. J. Obst. & Gynec., 48:510, 1944, etc.

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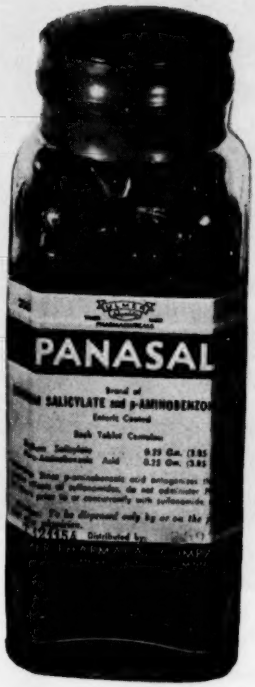

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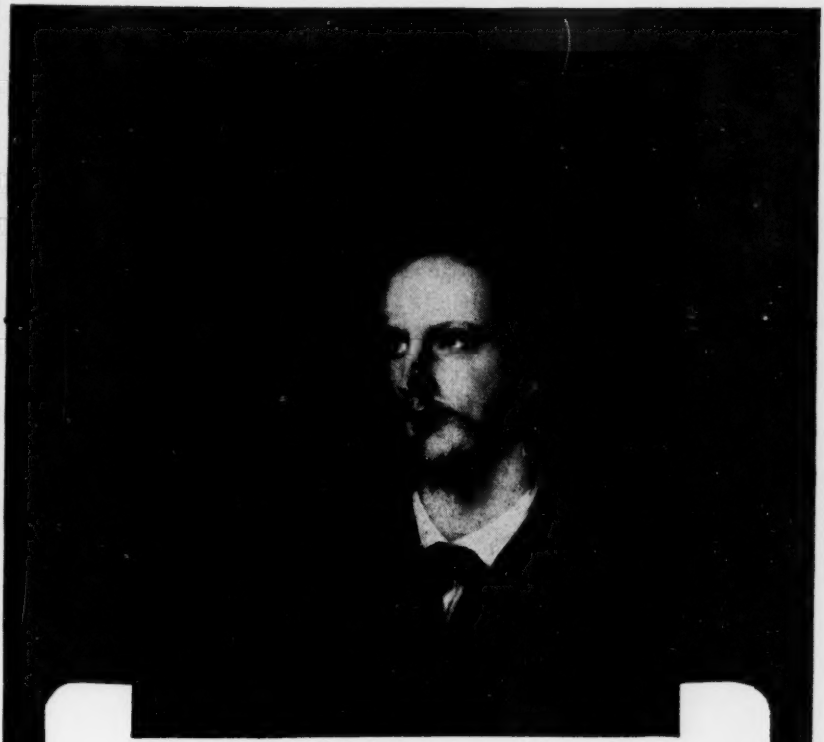

★ *Epileptic Men of Genius* ★

The famous English poet, Algernon Charles Swinburne, who began to show signs of epilepsy at the age of 25, is a prominent example that despite epilepsy a man may develop to true greatness.

Comparative studies have shown that in some cases better control of grand mal as well as petit mal seizures can be obtained with Mebaral than with corresponding doses of other antiepileptic drugs. Mebaral produces tranquillity with little or no drowsiness. It is particularly desirable not only in epilepsy but also in the management of anxiety states and other neuroses. The fact that Mebaral is almost tasteless simplifies its administration to children. Average dose for children ½ to 3 grains, adults 3 to 6 grains daily. Tablets ½, 1 ½ and 3 grains.

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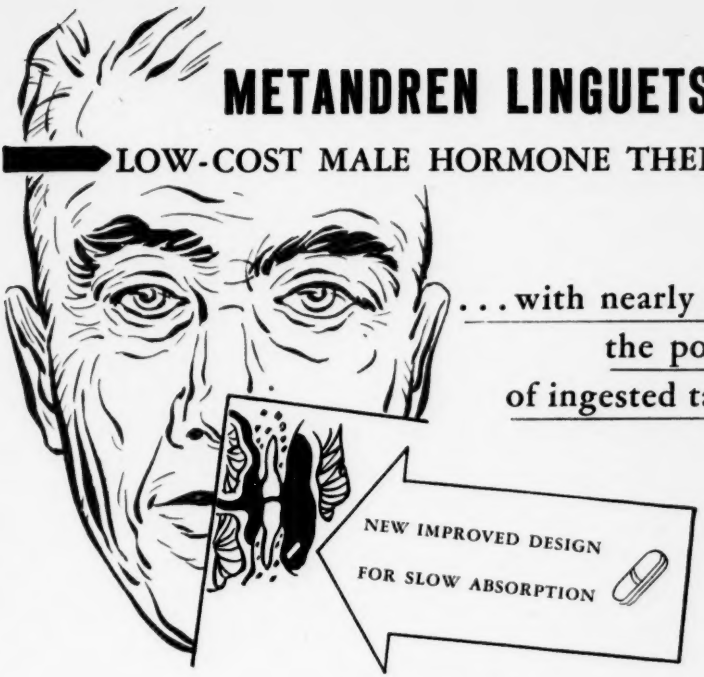

. . . with nearly twice the potency of ingested tablets

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1. Lisser, H.: Calif. & West. Med., 64: 177, 1946
2. Tyler, E. T.: J.A.M.A., 139: 9, Feb., 1949.

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